NATIONAL QUALITY FORUM

Memo

TO: American Medical Association - Physician Consortium for Performance Improvement

FR: NQF GI/GU Project Staff

RE: GI/GU Endorsement Maintenance Pilot Project: Stage two checklist

DA: September 28, 2012

GI/GU Endorsement Maintenance Pilot Project, 2012

Thank you for your participation and concept submission to the GI/GU Endorsement Maintenance Pilot Project. Please carefully review the instructions below for next steps.

Preparation for submission of recommended concepts to stage two

1. Keep in mind, while the measure submission forms for recommended concepts opens in early November, approval of concepts is finalized with Board of Directors approval on November 30.

2. Review all requirements for measure submission and criteria to be suitable for endorsement:
   - Ensure that evidence remains current and consistent with concept
     - Check if there have been any major changes in the evidence base supporting the approved concept. If yes, provide the citation and copy of the study or article and discuss the impact on the measure concept.
     - If there are any changes in the concept from that which was approved, identify those changes and discuss the relevance of the evidence to the approved concept and the updated concept.
   - Ensure that testing requirements have been satisfied
     - Testing requirements are available in the Measure Testing Task Force report

3. Review the Developer Guidebook for additional resources and information for preparing your stage two measure submission. The updated guidebook will be available once stage two submission forms are opened and will also be distributed by NQF Technical Assistance Staff.

4. **Notify NQF project staff by October 25, 2012** if you plan to submit full specifications and testing for approved concepts by the December 19, 2012 stage

two measure submission deadline.

Yes, we plan to submit full specifications and testing for approved concepts by the December 19, 2012 stage two deadline.

5. You will be required to submit at least one of your fully specified and tested measures on or prior to the **technical assistance deadline on December 3, 2012**, for a technical review for completeness and responsiveness by the NQF staff.

So noted.

6. Measure submissions must be complete and responsive to ALL questions in order to be advanced to the Steering Committee for consideration and evaluation.

Concept(s) Recommended for Approval: AMA-PCPI

Provide a response for EACH Committee recommendation describing your rationale for implementing (or not) the recommendation and any additional considerations.

Upload this document to your online measure submission form for review by the Committee in stage two.

0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	
Committee Recommendations to Developer	**Developer Response**

0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	
Rather than measuring whether the appropriate interval was recommended, consider specifying the measure to look at colonoscopies performed and then do a look back to when their last colonoscopy was performed to determine if it was in the last 10 years. Implementing these changes would make the measure closer to an outcome measure that would be more impactful. The Committee recognized that do a prospective outcome measure is difficult to based on availability of data.	Although the PCPI appreciates the suggestion, for average risk individuals, there is concern that relying on confirmation of prior pathology and absolute intervals would place an undue burden on the referring and performing physician 10 years or more after the prior exam. During that interval many patients relocate and employ different physicians or delivery systems. Many patients change insurance carriers or migrate to Medicare coverage, yielding greater difficulty with tracking the index procedure at time of follow-up. Pathology results are often missing at late follow-up 10 years later. Appropriate guidance on follow-up intervals is an expectation of the consultation inherent in the procedure. Thereafter the patient management is primarily guided by the primary care physician. As for low risk patients, the performing endoscopist should be responsible for providing appropriate follow-up guidance, based not on subjectivity, but on the findings of his/her procedure, resulting pathology, the patient and family history, and national guidelines. This becomes the basis for the patient, primary provider and subsequent endoscopist to anticipate and plan for the next surveillance interval. The subsequent endoscopist should have access to the prior report and guidance and should adhere to standard guidelines based on the findings.

0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	
Patients aged 50 years and older receiving a screening colonoscopy who had a recommendation to repeat colonoscopy in 1 year or less due to poor bowel cleansing	The measure has an exception built in for medical reason(s) for not recommending at least a 10 year follow-up interval (eg, above average risk patient, inadequate prep). The PCPI recommends that exception rates be reported alongside performance rates.
Consider adjusting the upper age limit for older patients, including inflammatory bowel disease, and better define "above average risk".	"Above average risk" is defined by the clinical guidelines; for example, the 2008 joint guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology on Screening and surveillance for the early detection of colorectal cancer and adenomatous polyps defines "increased or high risk" as "with a personal or family history of colorectal cancer (CRC) or adenomas, inflammatory bowel disease, or high-risk genetic syndromes." The PCPI thanks the SC for the recommendation of including an upper age limit and inflammatory bowel disease and will bring these concepts back to the Expert Work Group when the measure is due for review & enhancement.
Clarify in the specifications whether the exceptions are included in the denominator or should be calculated as a separate measure.	No, the exceptions are not included in the denominator if there is a valid medical reason for not recommending at least a 10 year follow-up interval (eg, above average risk patient, inadequate prep). We encourage exception rates to be reported alongside of performance rates, for increased transparency, but exceptions are not calculated as separate measures.
Due to the differences in populations and the measure focus, harmonization between this concept and 0659 will not be needed.	Thank you.

0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	
Committee Recommendations to Developer	**Developer Response**
The developer should expand on the available evidence and on the details of the meta-analysis to better demonstrate the body of evidence available to support this measure focus.	We have done our best to present the body of evidence, and the NQF Steering Committee seemed satisfied with the available evidence and details described in the submission form during stage 1 of this process.
eMeasure specifications should be submitted in stage 2.	Yes, we have an HQMF eMeasure for 0659, which will be submitted in stage 2.

0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	
The interval specified in the measure does not match the recommendations in the evidence 3+ years versus 5 years; consider how these can be aligned to ensure the measure is evidence-based.	The interval for this measure (at least 3 years) is consistent with the evidence-based guidelines that were the basis for the measure, which recommend an interval of 3-5 years for patients with adenomatous polyps that are less than 10 cm. Additional medical reasons, such as high risk for colorectal cancer or family history of colorectal cancer, would qualify for the use of the medical exclusion. Several public comments received during the measure development process requested that the Work Group stratify the intervals based on the size of the polyps. For example, recommended surveillance intervals for HP polyps, every 5-7 years, for TA polyps < 10 mm, every 5 years, for TA polyps 10-20 mm, every 3 years, for TA polyps >20 mm & TVAs, every 1 year for 2-3 years, then every 3 years. The Work Group spent considerable time discussing different intervals depending on size. The Work Group decided that doing so would be problematic for the following reasons: 1. The measure would require a separate code for each interval, which would add additional burden on physicians reporting on the measure and would complicate documentation and feasibility. 2. The guidelines are very specific for patients with a history of polyps; the general guideline recommends that patients receive follow-up in 3 to 5 years, a shorter interval of follow-up is recommended in those patients with numerous adenomatous (>10) polyps and in those in whom the colonoscopy was incomplete or the preparation was inadequate. The medical exception in the measure accounts for this difference.

0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	
Due to the differences in populations and the measure focus, harmonization between this concept and 0658 will not be needed.	Thank you.

Measure Submission and Evaluation Worksheet 6.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

NQF #: 0658 NQF Project: GI and GU Project

(for Endorsement Maintenance Review)
Original Endorsement Date: Most Recent Endorsement Date: Evaluation Form Created: March 22, 2013

BRIEF MEASURE INFORMATION

De.1 Measure Title: Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients

Co.1.1 Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

De.2 Brief Description of Measure: Percentage of patients aged 50 years 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 their colonoscopy report.

2a1.1 Numerator Statement: Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

2a1.4 Denominator Statement: All patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy

2a1.8 Denominator Exclusions: Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, above average risk patient, inadequate prep)

1.1 Measure Type: Process
2a1. 25-26 Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry, N/A
2a1.33 Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team
1.2-1.4 Is this measure paired with another measure? No

De.3 If included in a composite, please identify the composite measure (*title and NQF number if endorsed*): N/A

1. IMPACT, OPPORTUITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence.
Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)

1a. High Impact: H☐ M☐ L☐ I☐
(*The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.*)

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

De.4 Subject/Topic Areas *(Check all the areas that apply)*: Gastrointestinal (GI), Gastrointestinal (GI) : Polyps, Prevention, Gastrointestinal (GI) : Screening
De.5 Cross Cutting Areas (*Check all the areas that apply)*: Overuse, Prevention

1a.1 Demonstrated High Impact Aspect of Healthcare:
Affects large numbers; Frequently performed procedure; High resource use

1a.2 If "Other," please describe: N/A

1a.3 Summary of Evidence of High Impact *(Provide epidemiologic or resource use data)*:
Colorectal cancer is the 2nd leading cause of cancer death in the United States. 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).

1a.4 Citations for Evidence of High Impact cited in 1a.3:
Zauber, et al. Evaluating test strategies for colorectal cancer screening; a decision analysis for the US preventive services task force. Ann Int Med Vol 149, 2008.
Lieberman, DA, Faigel, DO, Logan, J, Mattek, N, Holub, J, Eisen, G, Morris, C, Smith, R, Nadel, M. Assessment of the Quality of Colonoscopy Reports: Results from a multi-center consortium. Gastrointest Endosc Vol 69, 2009.

1b. Opportunity for Improvement: H☐ M☐ L☐ I ☐
(*There is a demonstrated performance gap - variability or overall less than optimal performance*)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:
Guideline recommendations support screening colonoscopy at 10 year intervals, for average risk patients. Non-adherence to guideline recommendations increases patients to unnecessary risk via procedural harms and complications. Colonoscopy screening at more frequent intervals also contributes to increased costs to patients and insurers.

1b.2 Summary of Data Demonstrating Performance Gap *(Variation or overall less than optimal performance across providers)*:
[*For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]
A recent community based multi-organ cancer screening study in 3627 patients noted that 49 % of low risk patients with adequate negative colonoscopic examinations underwent follow-up surveillance procedures within 7 years (median 3.1 yrs) of their first study, and 35% of low risk patients with two negative exams underwent a third study at a median of 3.3 years after the prior study, despite guidelines for repeat examination at 10 years (Schoen, 2010). Variations in the recommended time interval between colonoscopies also exist for patients with normal colonoscopy findings. In a 2006 study of 1282 colonoscopy reports, recommendations were consistent with current guidelines in only 36.7% of cases. (Krist et al, 2007).

1b.3 Citations for Data on Performance Gap: [*For Maintenance – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
Schoen R, Pinsky PF, Weissfeld JL, et al. Utilization of Surveillance Colonoscopy in Community Practice. Gastroenterology Vol 138, 2010.
Krist, AH, jones, RM, Woolf, SH et al. Timing of Repeat Colonoscopy: Disparity Between Guidelines and Endoscopists' Recommendation. American Journal of Preventive Medicine. 2007.

1b.4 Summary of Data on Disparities by Population Group *(for example by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability, etc. If you do not have data on your specific measure, perform a literature search/review and report data for the measure or similar appropriate concept.)*: [*For Maintenance –Descriptive statistics for performance results for this measure by population group*]
After a search of the medical literature, we are not aware of any publications/evidence outlining disparities in this area.

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
N/A

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes☐ No☐ If not a health outcome, rate the body of evidence.

Quantity: H☐ M☐ L☐ I☐ Quality: H☐ M☐ L☐ I☐ Consistency: H☐ M☐ L☐ I☐

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes☐
L	M-H	M	Yes☐ IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No☐
M-H	L	M-H	Yes☐ IF potential benefits to patients clearly outweigh potential harms: otherwise No☐
L-M-H	L-M-H	L	No ☐

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	Does the measure pass subcriterion1c? Yes☐ IF rationale supports relationship

SEE ATTACHED EVIDENCE SUBMISSION FORM

Was the threshold criterion, *Importance to Measure and Report*, met?
(*1a & 1b must be rated moderate or high and 1c yes*) Yes☐ No☐
Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.
For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & 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. (evaluation criteria)
Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See guidance on measure testing.

S.1 Measure Web Page *(In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained?
www.physicianconsortium.org

2a1.1 Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome)*:
Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

2a1.3 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, codes with descriptors, and/or specific data collection items/responses*:
Patients will be counted in the numerator if there is reference in the final colonoscopy report that the appropriate follow-up interval for the next colonoscopy is at least 10 years from the date of the current colonoscopy (ie, the colonoscopy performed during the

measurement period).

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
All patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy

2a1.5 Target Population Category *(Check all the populations for which the measure is specified and tested if any)*:
Senior Care

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
The denominator of this measure includes patients at least 50 years of age who receive a screening colonoscopy during the measurement period. The denominator details will include the patient age criterion and applicable CPT, G-Codes and SNOMED-CT procedure codes for a screening colonoscopy. The procedures that will be identified include only those without biopsy or polypectomy, meaning the patient did not have any polyps removed or biopsied during the colonoscopy procedure.

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, above average risk patient, inadequate prep)

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0658, exceptions may include medical reason(s) (eg, above average risk patient, inadequate prep) for not recommending at least a 10 year follow-up interval. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows:
EHR Specifications:
eSpecifications attached

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses)*:
We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13)*: No risk adjustment or risk stratification 2a1.12 If "Other," please describe: N/A

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.)*:
N/A

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a

webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score:
Rate/proportion

If other: N/A

2a1.19 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

2a1.20 Calculation Algorithm/Measure Logic*(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; 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 the performance measure 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 exception when exceptions have been specified [for this measure: medical reason(s) (eg, above average risk patient, inadequate prep)]. 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 number of patients 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 a quality failure.
Calculation algorithm is included in attachment 2a1.30.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:
Included in attached appendix

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):
N/A

2a1.25 Data Source *(Check all the sources for which the measure is specified and tested*). If other, please describe:
Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*):
N/A

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment:
N/A

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:
Final_eSpec_0658.pdf

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested)*:
Clinician : Group/Practice, Clinician : Individual, Clinician : Team

2a1.34-35 Care Setting *(Check all the settings for which the measure is specified and tested)*:
Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic

If other: N/A

2a. RELIABILITY. Precise Specifications and Reliability Testing: H☐ M☐ L☐ I ☐

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H☐ M☐ L☐ I ☐

2c. Disparities in Care: H☐ M☐ L☐ I ☐ NA☐ (*If applicable, the measure specifications allow identification of disparities.*)

SEE ATTACHED MEASURE TESTING FORM

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?
(*Reliability and Validity must be rated moderate or high*) Yes☐ No☐
Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers) 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. (evaluation criteria)

3.1 Current and Planned Use *(NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported withi n 6 years of initial endorsement in addition to performance improvement.)*:

Current and Planned Use (check all the current and planned uses; for any current uses that are checked, provide a URL for the specific program)

Planned	Current	For current use, Provide URL
Public Reporting	Professional Certification or Recognition Program;Quality Improvement with Benchmarking (external benchmarking to multiple organizations)	http://giquic.gi.org/; www.agaregistry.org

3a. Accountability and Transparency: H☐ M☐ L☐ I ☐
(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.)

3a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

- Geographic area and number and percentage of accountable entities and patients included

Current Use 1
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 2
The AGA Digestive Health Oucomes Registry is a procedure-focused benchmarking registry using established quality indicators. The registry has been in development since 2009 and began collecting data in May of 2010. The American Gastroenterological Association established the AGA Registry. The AGA Registry
is derived from national evidence-based measures developed by gastroenterologists. It is a tool for gastroenterologists who want to benchmark their practices, proactively manage patient care and measure the appropriate use of resources. The AGA Registry has been operational for over two years and is open to physicians, physician assistants and nurse practitioners. The geographic area is the entire United States.
www.agaregistry.org

3a.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 block implementation?)*
The PCPI believes that the reporting of participation information is a beneficial first step on a trajectory toward the public reporting of performance results, which is appropriate since the measure has been tested and the reliability of the performance data has been validated. Continued NQF endorsement will facilitate our ongoing progress toward this public reporting objective.

3a.3 If not currently publicly reported OR used in at least one 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 has been proposed for inclusion in PQRS 2013.

3b. Improvement: H☐ M☐ L☐ I ☐
(Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated.6 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.)

3b.1. Provide data that demonstrate improvement in performance and/or health. (Not required for initial endorsement unless available.)
Include:

- Source of Data
- Geographic area and number and percentage of accountable entities and patients included
- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)

None

3b.2. 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.

3c. Unintended Consequences: H☐ M☐ L☐ I ☐
(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)

3c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.
We are not aware of any unintended consequences related to this measurement.

Overall, to what extent was the criterion, *Usability*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)

4a. Data Generated as a Byproduct of Care Processes: H☐ M☐ L☐ I ☐

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*
Data used in the measure are:
Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

4b. Electronic Sources: H☐ M☐ L☐ I ☐

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields)*:
ALL data elements are in defined fields in electronic health records (EHRs)

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:
N/A

4d. Data Collection Strategy/Implementation: H☐ M☐ L☐ I ☐

4d.1 Describe what you have learned/modified 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 *(e.g., fees for use of proprietary measures)*:
This measure was found to be reliable and feasible for implementation.

4d.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

Overall, to what extent was the criterion, *Feasibility*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes☐ No☐
Rationale:

If the Committee votes No, STOP.
If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND 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 before a final recommendation is made.

5.1 If there are related measures *(either same measure focus or target population)* or competing measures *(both the same measure focus and same target population*), list the NQF # and title of all related and/or competing measures:
0572 : Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy
0659 : Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
ACP-018-10 : Endoscopy/Polyp Surveillance: Comprehensive Colonoscopy Documentation
0034 : Colorectal Cancer Screening
0392 : Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized?
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 intends to capture one of four different types of colorectal cancer screening tests, instead of looking specifically at the interval between colonoscopies. Measure 0659 focuses on a different patient population, as the patients in 0659 have had a history of a prior colonic polyp(s) in previous colonoscopy findings. The patient population in measure 0659 has a different follow up interval recommendation, according to evidence based guidelines.

5b. Competing Measure(s)

5b.1 If this measure has 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.

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

Co.2 Point of Contact: Mark S. | Antman, DDS, MBA | mark.antman@ama-assn.org | 312-464-5056

Co.3 Measure Developer if different from Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

Co.4 Point of Contact: Mark S. | Antman, DDS, MBA | mark.antman@ama-assn.org | 312-464-5056

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development

Ad.1 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.

Co-chairs
John Allen, MD, MBA, AGAF (Gastroenterology)
Doug Faigel, MD (Gastroenterology)

Work Group Members
Nancy Baxter, MD, PhD, FACRS, FACS (Colon and Rectal Surgery)
Stephen Bickston, MD, AGAF (Gastroenterology)
Joel V. Brill, MD, AGAF, FASGE, FACG, CHCQM (Gastroenterology)
Kirk Brandon, MBA (Business Administration/Coding)
Jason A. Dominitz, MD, MHS, AGAF (Gastroenterology)
Ira L. Flax, MD, FACG (Gastroenterology)
Karen E. Hall, MD, PhD (Geriatrics)
Robert Haskey, MD, FACS (General Surgery, Health Plan representative)
Brian C. Jacobson, MD, MPH (Gastroenterology)
David Lieberman, MD (Gastroenterology)
Klaus Mergener, MD, PhD, CPE, FACP, FACG, FASGE, FACPE (Gastroenterology)
Bret Petersen, MD, FASGE (Gastroenterology)
Irving M. Pike, MD, FACG (Gastroenterology)
Bart Pope, MD (Family Medicine)
Harry Sarles, MD, FACG (Gastroenterology)
Kay Schwebke, MD, MPH (Specialty: Internal Medicine, Infectious Diseases & Medical Informatics)
Tom Lynn, MD (Medical Informatics, Methodology)
Emily E. Volk, MD, FCAP (Pathology)
Michael Weinstein, MD Specialty: Gastroenterology)

American Gastroenterological Association
Debbie Robin, MSN, RN, CHCQM

American Society for Gastrointestinal Endoscopy
Jill Blim
Chris Recker, RN, MPH
Martha Espronceda

American College of Gastroenterology
Julie Cantor-Weinberg, MPP
American Medical Association
Joseph Gave, MPH
Karen Kmetik, PhD
Shannon Sims, MD, PhD
Beth Tapper, MA

Consortium Consultants
Rebecca Kresowik
Timothy Kresowik, MD

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.3 Year the measure was first released: 2008
Ad.4 Month and Year of most recent revision: 08/2008
Ad.5 What is your frequency for review/update of this measure? See Ad.9.
Ad.6 When is the next scheduled review/update for this measure? 08/2013

Ad.8 Disclaimers: N/A

Ad.9 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.
Date of Submission (*MM/DD/YY*): Jul 09, 2012

NATIONAL QUALITY FORUM—Evidence (1c) Pilot Submission Form

Measure Title: Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
Date of Submission: 7/16/12

- Respond to all questions with answers immediately following the question.
- Maximum of 6 pages (*6 pages includes questions/instructions in the form*); minimum font size 11 pt
- All information needed to demonstrate meeting the evidence criterion (1c) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed.
- See NQF guidance on evaluating evidence. Contact NQF staff for examples, resources, or questions.

STRUCTURE-PROCESS-OUTCOME RELATIONSHIP
1c.1.This is a measure of:
Outcome
☐ Health outcome: Click here to name the health outcome
☐ Intermediate clinical outcome: Click here to name the intermediate outcome
X Process: Recommendation and documentation of follow-up interval for normal colonoscopy
☐ Structure: Click here to name the structure
☐ Other: Click here to name what is being measured

HEALTH OUTCOME MEASURE *If not a health outcome, skip to 1c.3*
If the measure focus identified in 1c.1 is a health outcome, answer 1c.2 and 1c.2.1.
1c.2. Briefly state or diagram how the health outcome is related to at least one healthcare structure, process, intervention, or service.

1c.2.1. **State the rationale supporting the relationship between the health outcome and at least one healthcare structure, process, intervention, or service**.

Note: For health outcome measures, no further information is required

STRUCTURE, PROCESS, OR INTERMEDIATE OUTCOME MEASURE
If the measure focus identified in 1c.1 is a structure, process, or intermediate outcome answer all the following questions (except as indicated by skip pattern).
1c.3. Briefly state or diagram how the measure focus is related to desired health outcomes and proximity to desired health outcomes. *(Do not summarize the evidence here.)*

Recommendation and documentation of 10 year follow up interval >>>physician adherence to guideline recommendations>>>reduction in patient risk/complications and decrease in cost

1c.4. Is there a guideline recommendation supporting the measure focus identified in 1c.1.? Yes X No ☐
If no, skip to #1c.6
If yes, *answer 1c.4.1-1c.5.*

1c.4.1. **Guideline citation** (*including date*):
American Cancer Society/US Multisociety Task Force on Colorectal Cancer/American College of Radiology (ACS/USMSTF/ACR). 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 2008 May-Jun;58(3):130-60.

Douglas K. Rex , MD, FACG, David A. Johnson , MD,FACG, et al, American College of Gastroenterology Guidelines for Colorectal Cancer Screening 2008. Am J Gastroenterology advance online publication, 24 February 2009; doi: 10.1038/ajg.2009.104.

1c.4.2. **URL** (*if available online*):
http://www.gastrojournal.org/article/S0016-5085(08)00232-1/fulltext

http://www.medicine.nevada.edu/residency/lasvegas/internalmed/documents/coloncaGuideline.pdf

1c.4.3. **Identify guideline number and/or page number**:
ACS/USMSTF/ACR: p. 1582; Rex, et al: pp. 2-3

1c.4.4. **Quote verbatim, the specific guideline recommendation**:
At present, CSPY (colonoscopy) every 10 years is an acceptable option for CRC screening in average-risk adults beginning at age 50 years. (ACS/USMSTF/ACR 2008)

The preferred CRC prevention test is colonoscopy every 10 years, beginning at age 50. (Grade 1B) (Rex, et al, 2009)

1c.4.5. **Grade assigned to the recommendation with definition of the grade**:
ACS/USMSTF/ACR 2008: Not graded.

Rex, et al, 2009: Grade 1B, which is defined as 1B/Strong recommendation, moderate quality evidence; Benefits clearly outweigh risk and burdens, or vice versa; RCTs with important limitations (inconsistent results, methodological flaws, indirect, or imprecise) or exceptionally strong evidence from observational studies; Strong recommendation, can apply to most patients in most circumstances without reservation

1c.5. Did the guideline developer systematically review and grade the body of evidence for the specific guideline recommendation? Yes X No ☐ *If no, skip to #1c.6*

If yes, *answer 1c.5.1. (**Note:** Findings of the systematic review of the body of evidence for the guideline recommendation must be reported in 1c.8-1c.13.)*
1c.5.1. **Grade assigned to the body of evidence with definition of the grade**:

ACS/USMSTF/ACR 2008:The guideline developer indiated that an evidence review was performed, but the body of evidence was not graded.

Rex, et al, 2009: The guideline developers did not assign a specific grade to the body of evidence, but explained their systematic evidence review as follows: "The evidence that colonoscopy prevents incident CRCs and reduces the consequent mortality from CRC is indirect but substantial. No prospective randomized controlled trial, comparing colonoscopy with no screening, has been carried out. However in a randomized controlled trial, involving only 800 patients, in which flexible sigmoidoscopy with colonoscopy carried out for any polyp detected was compared with no screening, the screening strategy

resulted in an 80 % reduction in the incidence of CRC. In addition, at the University of Minnesota, a randomized controlled trial was carried out comparing annual vs. biennial fecal occult blood testing with rehydration with no screening. Screening resulted in a 20% incidence reduction in CRC, which appeared to have resulted from detection of large adenomas by fecal occult blood testing and subsequent colonoscopy and polypectomy. Cohort studies involving patients, who have undergone colonoscopy and polypectomy with apparent clearance of colonic neoplasia, have shown a 76 – 90% reduction in the incidence of CRC in comparison with reference populations. Case – control studies of colonoscopy showed a 50% reduction in mortality from CRC in a US Veterans Administration population, and there was an 80% reduction in the CRC incidence in the German population . Population-based studies in the United States have associated increases in the use of colonoscopy with earlier and more favorable stages in CRC presentation , and with reductions in the incidence of CRC. Additional evidence for a benefit from colonoscopy screening is extrapolated from case – control studies of sigmoidoscopy, which have shown mortality and incidence reductions of distal CRC of 60 and 80%, respectively, in screening populations."

1c.6. Is there another published systematic review of the body of evidence supporting the measure focus identified in 1c.1? *(other than from the guideline cited above, e.g., Cochrane, AHRQ, USPSTF)*
Yes☐ NoX *If no, skip to #1c.7*

If yes, *answer 1c.6.1-1c.6.3. (**Note:** Findings of the systematic review of the body of evidence must be reported in 1c.8-1c.13.)*
1c.6.1. **Citation** (*including date*):

1c.6.2. **URL** (*if available online*):

1c.6.3. **Grade assigned to the body of evidence with definition of the grade**:

If a systematic review of the evidence was identified in either 1c.5 or 1c.6, skip to 1c.8

1c.7. If a systematic review of the body of evidence was not identifed and reported in 1c.5 or 1c.6, did the measure developer perform a systematic review of the body of evidence supporting the measure focus identified in 1c.1? Yes☐ No☐

If yes, *answer 1c.7.1-1c.7.3. (**Note:** Findings of the measure developer's systematic review of the body of evidence must be reported in 1c.8-1c.13 and unpublished evidence review products such as evidence tables provided in an appendix.)*
1c.7.1. **Who conducted the measure developer's systematic review of the body of evidence**?

1c.7.2. **Grade assigned to the body of evidence with definition of the grade**:

1c.7.3. **Describe the process used for the systematic review**:

If no systematic review of the body of evidence identified in 1c.5, 1c.6, or 1c.7, the evidence criterion can not be met.

FINDINGS FROM SYSTEMATIC REVIEW OF BODY OF THE EVIDENCE SUPPORTING THE MEASURE FOCUS
(Items 1c.8-1c.13 must be answered and should support the measure focus identified in 1c.1. If more than one systematic review was identified (1c.5, 1c.6, and 1c.7), provide a separate response for each.)

1c.8. What is the time period covered by the body of evidence? (*provide the date range, e.g., 1990-2010*). Date range:
ACS/USMSTF/ACR 2008: January 2002 and March 2007

Rex, et al, 2009: The date range of the studies reviewed is not provided.

QUANTITY AND QUALITY OF BODY OF EVIDENCE

1c.9. How many and what type of study designs are inlcuded in the body of evidence? (*e.g., 3 randomized controlled trials and 1 observational study*)
ACS/USMSTF/ACR 2008: While the number and type of study designs are not described by the guideline developers, the article did say, "Most of the information supporting the use of the other colorectal screening tests [including CSPY] is based on observational and inferential evidence. In this review, priority was placed on studies of asymptomatic average-risk or higher-risk populations that were followed by testing with colonoscopy in all or nearly all study participants as a validation measure."

Rex, et al, 2009: The number and type of study designs are not provided.

1c.10. What is the overall quality of evidence <u>across studies</u> in the body of evidence? (*discuss the certainty or confidence in the estimates of effect due to study factors such as design flaws, imprecision due to small numbers, indirectness of studies to the measure focus or target population*)

The overall quality of evidence across studies was not addressed in the guidelines or in the systematic reviews.

ESTIMATES OF BENEFIT AND CONSISTENCY ACROSS STUDIES IN BODY OF EVIDENCE

1c.11. What are the estimates of benefit—magnitude and direction of effect on outcome(s) <u>across studies</u> in the body of evidence? (*e.g., ranges of percentages or odds ratios for improvement/ decline across studies, results of meta-analysis, and statistical significance*)
ACS/USMSTF/ACR 2008: Again, while the magnitude and direction across studies was not described, the guideline developers did summarize other studies as follows: "The evaluation of incidence rates of CRC in adenoma cohorts after baseline CSPY and polypectomy is another form of evidence commonly cited to support CSPY for CRC screening. In the National Polyp Study, the incidence of CRC after clearing CSPY was reduced by 76% to 90% compared with 3 nonconcurrent reference populations. In an Italian adenoma cohort study with removal of at least one adenoma ≥5 mm, there was an 80% reduction in CRC incidence compared with expected incidence in a reference population. However, not all studies have shown the same level of protection. Combined data from 3 US chemoprevention trials showed incidence rates of CRC after clearing CSPY approximately 4 times that seen in the National Polyp Study, with no reduction in CRC incidence compared with data from the Surveillance Epidemiology and End Results (SEER) database in the United States, and 2 US dietary intervention trials also showed higher rates of incident CRC after clearing CSPY than were observed in the National Polyp Study. These differences may reflect exclusion of patients with sessile adenomas >3 cm in the National Polyp Study, more effective baseline clearing (13% of patients in the National Polyp Study had 2 or more baseline CSPY to complete clearing), or unmeasured differences in the average quality of CSPY between the studies. Overall, the data support the conclusion that CSPY with clearing of neoplasms by polypectomy has a significant impact on CRC incidence and thus, by extension, mortality. The magnitude of the protective impact is uncertain; it is not absolute, nor are apparent failures well understood. In a study of 35,000 symptomatic patients in Manitoba who had undergone a negative CSPY and who then were followed for 10 years, the investigators observed significant reductions in CRC incidence over time, but

the incidence reductions were less than 50% for each of the first 5 years and no more than 72% by 10 years. These findings suggest detection failures during the initial, apparently normal, CSPY."

Rex, et al, 2009: The magnitude and direction across studies was not described, but the guideline developers summarized the benefits of a number of studies as follows: "The evidence that colonoscopy prevents incident CRCs and reduces the consequent mortality from CRC is indirect but substantial. No prospective randomized controlled trial, comparing colonoscopy with no screening, has been carried out. However in a randomized controlled trial, involving only 800 patients, in which flexible sigmoidoscopy with colonoscopy carried out for any polyp detected was compared with no screening, the screening strategy resulted in an 80 % reduction in the incidence of CRC. In addition, at the University of Minnesota, a randomized controlled trial was carried out comparing annual vs. biennial fecal occult blood testing with rehydration with no screening. Screening resulted in a 20% incidence reduction in CRC, which appeared to have resulted from detection of large adenomas by fecal occult blood testing and subsequent colonoscopy and polypectomy. Cohort studies involving patients, who have undergone colonoscopy and polypectomy with apparent clearance of colonic neoplasia, have shown a 76 – 90% reduction in the incidence of CRC in comparison with reference populations. Case – control studies of colonoscopy showed a 50% reduction in mortality from CRC in a US Veterans Administration population, and there was an 80% reduction in the CRC incidence in the German population . Population-based studies in the United States have associated increases in the use of colonoscopy with earlier and more favorable stages in CRC presentation , and with reductions in the incidence of CRC. Additional evidence for a benefit from colonoscopy screening is extrapolated from case – control studies of sigmoidoscopy, which have shown mortality and incidence reductions of distal CRC of 60 and 80%, respectively, in screening populations."

1c.12. What harms were studied and how do they affect the net benefit—benefits over harms?
ACS/USMSTF/ACR 2008: The guideline developers have identified the following harms that have been studied, which they deem minimal in comparison to the benefits: "Controlled studies have shown the CSPY miss rate for large adenomas (≥10 mm) to be 6% to 12%. The reported CSPY miss rate for cancer is about 5%. CSPY can result in significant harm, most often associated with polypectomy, and the most common serious complication is postpolypectomy bleeding. The risk of postpolypectomy bleeding is increased with large polyp size and proximal colon location; however, small polyp bleeds are more numerous than large polyp bleeds because small polyps are so numerous. Another significant risk associated with CSPY is perforation. Perforation increases with increasing age and the presence of diverticular disease and was recently estimated to occur in 1 in 500 of a Medicare population and approximately 1 in 1000 screened patients overall.123 Because of the age effect, perforation rates measured in the Medicare population may overestimate the overall risk of perforation in CSPY; however, a large study in the Northern California Kaiser Permanente population also identified a perforation rate of 1 in 1000. In addition, cardiopulmonary complications such as cardiac arrhythmias, hypotension, and oxygen desaturation may occur, although these events rarely result in hospitalization. Cardiopulmonary complications represent about one half of all adverse events that occur during CSPY and usually are related to sedation. Thus, while screening CSPY has established benefits with regard to the detection of adenomas and cancer, complications related to CSPY are a significant public health challenge." However, despite these risks of harm, "A principal benefit of CSPY is that it allows for a full structural examination of the colon and rectum in a single session and for the detection of colorectal polyps and cancers accompanied by biopsy or polypectomy. All other forms of screening, if positive, require CSPY as a second procedure. Patient surveys indicate that patients willing to undergo invasive testing tend to choose CSPY as their preferred test. In addition to being a complete examination of the colon, individuals may also regard sedation during the procedure as an advantage. Patients in the same

practice who had undergone unsedated FSIG screening were more than twice as likely to say that they would not return for additional screening compared with those who had undergone CSPY with sedation."

Rex, et al, 2009: The guideline developers have identified the following harms that have been studied, which they deem outweighed by the benefits: "Screening colonoscopy can be associated with significant harm, particularly colonic perforation. Many perforations are related to polypectomy and because small polyps are so numerous, small polyp polypectomy perforations contribute substantially to the overall perforation risk. Perforations associated with removal of small polyps are unfortunate, because the overwhelming majority of these polyps will not harm patients. Effective removal of these polyps by cold snare polypectomy or biopsy techniques is possible, at least for very small polyps, and is not associated with either bleeding or perforation. In general, there are insufficient data available from randomized controlled trials to guide or mandate particular polypectomy techniques. Pending such trials, the ACG recommends that colonoscopists consider carefully the polypectomy techniques they utilize for small polyps with an aim to reduce the burden of perforation. On the other hand, the ACG acknowledges that use of effective polypectomy techniques is critical for adequate resection of larger polyps. Two studies have suggested that about one-quarter of incident cancers occurring after colonoscopy result from ineffective polypectomy. Overall, the perforation risk and the requirement for thorough bowel preparation are the major downsides of colonoscopy. [On the other hand,] Major advantages of colonoscopy as a screening test include that it is widely available, examines the entire colon, allows single-session diagnosis and treatment, is comfortable when carried out with sedation, and is the only test recommended at 10-year intervals. The incremental benefit of colonoscopy over sigmoidoscopy is the detection of patients with proximal colon neoplasia (particularly advanced adenomas), as well as large hyperplastic polyps that are not associated with distal neoplasia. Overall, sigmoidoscopy detects 60 – 70 % of the significant neoplasia detected by complete colonoscopy. The preference of most American patients is for highly effective strategies, as well as for strategies that provide high levels of comfort and thereby increase the chance that patients will return for additional testing. These are important rationales for the use of colonoscopy rather than sigmoidoscopy."

UPDATE TO THE SYSTEMATIC REVIEW(S) OF THE BODY OF EVIDENCE

1c.13. Are there new studies that have been conducted since the systematic review(s) of the body of evidence? Yes☐ NoX *If no, stop*

If yes,

1c.13.1. **For each new study provide: 1) citation, 2) description, 3) results, 4) impact on conclusions of systematic review**.

Measure Testing to Demonstrate Scientific Acceptability of Measure Properties

Measure Title: Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
Date of Submission: January 11, 2013
Type of Measure:

☐ Composite	☐ Outcome
☐ Cost/resource	X Process
☐ Efficiency	☐ Structure

This Word document template must be used to submit information for measure testing.

- **For all measures, sections 1, 2a2, 2b2, 2b3, 2b5 must be completed**
- **For outcome or resource use measures**, section **2b4** also must be completed
- If specified for **multiple data sources** (e.g., claims and medical records), section **2b6** also must be completed
- Respond to all questions with answers immediately following the question (*unless meet the skip criteria or those that are indicated as optional*).
- Maximum of 10 pages (*incuding questions/instructions; do not change margins or font size; contact project staff if need more pages*)
- All information on testing to demonstrate meeting the criteria for scientific acceptability of measure properties (2a,2b) must be in this form. An appendix for *supplemental* materials may be submitted, but there is no guarantee it will be reviewed.

1. DATA/SAMPLE USED FOR ALL TESTING OF THIS MEASURE
Often the same data are used for all aspects of measure testing. In an effort to eliminate duplication, the first five questions apply to all measure testing. If there are differences by aspect of testing, (e.g., reliability vs. validity) be sure to indicate the specific differences in question 7.

1.1. What type of data was used for testing? (*Check all the sources of data identified in the measure specifications and data used for testing the measure. Testing must be provided for all the types of data specified and intended for measure implementation*)

Measure Specified to Use Data From:	**Measure Tested with Data From:**
☐ abstracted from paper record	☐ abstracted from paper record
☐ administrative claims	☐ administrative claims
X clinical database/registry	X clinical database/registry
☐ abstracted from electronic health record	☐ abstracted from electronic health record
☐ eMeasure implemented in electronic health record	☐ eMeasure implemented in electronic health record
X other: eSpecification using the QDM, measure logic, value sets using national vocabulary standards.	☐ other:

1.2. If used an existing dataset, identify the specific dataset (*the dataset used for testing must be consistent with the measure specifications for target population and healthcare entities being measured; e.g., Medicare Part A claims, Medicaid claims, other commercial insurance, nursing home MDS, home health OASIS, clinical registry*).

Data 1

The data source is the GIQuIC (GI Quality Improvement Consortium, Ltd.) registry, a procedure-focused benchmarking registry using established quality indicators.

Data was collected electronically via endowriter, an automated endoscopy record system (not an EHR/EMR) or manually via a web portal. Data can be reported to PQRS. Additionally, registry participants use the data for their unit quality improvement programs and can report the data to programs such as ASGE's Endoscopy Unit Recognition Program.

http://giquic.gi.org/

Data 2

The data source is the AGA Digestive Health Oucomes Registry, a procedure-focused benchmarking registry using established quality indicators.

The data are collected via EMR as well as web-portal data entry. The EMR data are sourced through a certified data transmission and validation process. Data can be reported to PQRS.

www.agaregistry.org

1.3. What are the dates of the data used in testing?

Data 1

The data are for the time period July 2010-October 2012, and cover the entire United States.

Data 2

The data are for the time period January 2011 to December 2011, and cover the entire United States.

1.4. What levels of analysis were tested? (*testing must be provided for all the levels specified and intended for measure implementation, e.g., individual clinician, hospital, health plan*)
X**individual clinician** ☐ **group/practice** ☐ **hospital/facility/agency** ☐ **health plan** ☐ **other**:

Individual clinician

1.5. How many and which measured entities were included in the testing and analysis (by level of analysis and data source)? (*identify the number and descriptive characteristics of measured entities included in the analysis (e.g., size, location, type); if a sample was used, describe how entities were selected for inclusion in the sample*)

For this measure, the minimum number required to be included is 10 events. Given the structure of the PQRS program, a physician may choose to submit or not submit to PQRS on any given claim. Since these data contain results on a large number of physicians, limiting the reliability analysis to only those physicians who are participating in the program will eliminate the bias introduced by the inclusion of from physicians who are in the data but are not submitting claims to PQRS.

Data 1

An additional use of the GIQuIC registry would be for participants to use the data for completing their Self-Directed Practice Improvement Module as part of their recertification with ABIM. Since we are limiting the analysis to only those with 10 or more events due to the structure of PQRS reporting, to maintain consistency, we are also limiting to physicians who have 10 or more events for the purpose of recertification with ABIM.

177 physicians had all the required data elements and met the minimum number of quality reporting events (10) for inclusion in the reliability analysis. The average number of quality reporting events for physicians included is 81.16 for a total of 14,366 events. The range of quality reporting events for physicians included is from 587 to 10.

97% of the physicians were associated with ambulatory endoscopy centers, 2 % were at hospitals, and 1 % was with an office based practice. The average number of physicians per site was 13.6 with a range of 1 to 27 physicians per site. The centers were located in 13 different states across the US.

Data 2

20 physicians had all the required data elements and met the minimum number of quality reporting events (10) for inclusion in the reliability analysis. The average number of quality reporting events for physicians included is 95.55 for a total of 1,911 events. The range of quality reporting events for physicians included is from 389 to 12.

1.6. How many and which <u>patients</u> were included in the testing and analysis (by level of analysis and data source)? (*identify the number and descriptive characteristics of patients included in the analysis (e.g., age, sex, race, diagnosis); if a sample was used, describe how patients were selected for inclusion in the sample*)

Data 1

There were 14,366 patient included in this testing and analysis. These were the patients that were associated with physicians who had 10 or more patients eligible for this measure.

The average age was 58.9 with a range from 50 to 93 years old. 61.5% of the sample was female, 38.5% male. Racial breakout was as follows:

Race	Percentage of Total	Percentage with Known Race
African American	8.47%	10.61%
Asian Pacific	1.60%	2.01%
Hispanic	3.57%	4.47%
White, Non-Hispanic	66.20%	82.91%
Unknown	20.16%	

Data 2

There were 1,911 patient included in this testing and analysis. These were the patients that were associated with physicians who had 10 or more patients eligible for this measure.

1.7. If there are differences in the data or sample used for different aspects of testing (e.g., reliability, validity, exclusions, risk adjustment), identify how the data or sample are different for each aspect of testing reported below.

The same data sample from each registry was used for the respective reliability testing, performance testing, and exceptions analysis.

_____

2a2. RELIABILITY TESTING

***Note**: If accuracy/correctness (validity) of data elements was empirically tested, separate reliability testing of data elements is not required – report validity of data elements in 2b2*

2a2.1. What level of reliability testing was conducted? (*may be one or both levels*) ☐ **Critical data elements used in the measure** (*e.g., inter-abstractor reliability*) X**Performance measure score** (e.g., *signal-to-noise*)

2a2.2. For each level checked above, describe the method of reliability testing and what it tests (*describe the steps—do not just name a method; what type of error does it test; what statistical analysis was used*)

Reliability of the computed measure score was measured as the ratio of signal to noise. The signal in this case is the proportion of the variability in measured performance that can be explained by real differences in physician performance. Reliability at the level of the specific physician is given by:

Reliability = Variance (physician-to-physician) / [Variance (physician-to-physician) + Variance (physician-specific-error]

Reliability is the ratio of the physician-to-physician variance divided by the sum of the physician-to-physician variance plus the error variance specific to a physician. A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in physician performance.

Reliability testing was performed by using a beta-binomial model. The beta-binomial model assumes the physician performance score is a binomial random variable conditional on the physician's true value that comes from the beta distribution. The beta distribution is usually defined by two parameters, alpha and beta. Alpha and beta can be thought of as intermediate calculations to get to the needed variance estimates.

Reliability is estimated five different points: at the minimum number of quality reporting events for the measure; at the mean number of quality reporting events per physician; and at the 25th, 50th and 75th percentiles of the number of quality reporting events.

2a2.3. For each level checked above, what were the statistical results from reliability testing? (e.*g., percent agreement and kappa for the critical data elements; distribution of reliability statistics from a signal-to-noise analysis and association with case volume*)

Data 1

For this measure, the reliability at the minimum level of quality reporting events (10) was 0.79. The average number of quality reporting events for physicians included is 81.16. The reliability at the average number of quality reporting events was 0.97

Description	Number of events	Reliability
Average	81	0.969
Minimum	10	0.797
75th percentile	98	0.975
50th percentile	53	0.954
25th percentile	21	0.892

Data 2

For this measure, the reliability at the minimum level of quality reporting events (10) was 0.86. The average number of quality reporting events for physicians included is 95.55. The reliability at the average number of quality reporting events was 0.98

Description	Number of events	Reliability
Average	96	0.979
Minimum	10	0.855
75th percentile	135	0.983
50th percentile	28	0.969
25th percentile	18	0.925

2a2.4 What is your interpretation of the results in terms of demonstrating reliability? (i.e., *what do the results mean and what are the norms for the test conducted?*)

Data 1

This measure has moderate reliability when evaluated at the minimum level of quality reporting events and high reliability at the median number of events (50th percentile), and at average and greater number of quality events. This suggests that for physicians with an average or greater number of events the measure has high reliability.

Data 2

This measure has high reliability when evaluated at the minimum level of quality reporting events and high reliability at the median number of events (50th percentile), and at average and greater number of quality events. This suggests that for physicians with an average or greater number of events the measure has high reliability.

Data analyses were conducted by using SAS/STAT software, version 8.2 (SAS Institute, Cary, North Carolina).

2b2. VALIDITY TESTING

2b2.1. What level of validity testing was conducted? (*may be one or both levels*)

☐ **Critical data elements**

☐ **Performance measure score**

☐ **Empirical validity testing**

X Systematic assessment of face validity of performance measure score as an indicator of quality or resource use (*i.e., is an accurate reflection of performance quality or resource use and can distinguish performance*)

2b2.2. For each level checked above, describe the method of validity testing and what it tests (*describe the steps—do not just name a method; what was tested, e.g., accuracy of data elements compared to authoritative source, relationship to another measure as expected; what statistical analysis was used)*

All PCPI performance measures are assessed for content validity by a panel of expert work group members during the development process. Additional input on the content validity of draft measures is obtained through a 30-day public comment period and by also soliciting comments from a panel of consumer, purchaser, and patient representatives convened by the PCPI specifically for this purpose. All comments received are reviewed by the expert work group and the measures adjusted as needed. Other external review groups (eg, focus groups) may be convened if there are any remaining concerns related to the content validity of the measures.

An expert panel was used to systematically assess face validity of the measure. The panel was asked to rate their agreement with the following statement:

"The scores obtained from the measure as specified will accurately differentiate quality across providers."

Scale 1-5, where 1=Strongly Disagree; 3=Neither Disagree nor Agree; 5=Strongly Agree

The expert panel included 21 members from the following specialty areas: gastroenterology, colon and rectal surgery, general surgery, health plans, internal medicine, pathology , family medicine, infectious diseases and medical informatics.

John Allen, MD, MBA, AGAF (Gastroenterology), Minneapolis, MN
Doug Faigel, MD (Gastroenterology), Scottsdale, AZ
Nancy Baxter, MD, PhD, FACRS, FACS (Colon and Rectal Surgery) Arlington Heights, IL
Stephen Bickston, MD, AGAF (Gastroenterology)
Joel V. Brill, MD, AGAF, FASGE, FACG, CHCQM (Gastroenterology), Phoenix, AZ
Kirk Brandon, MBA (Business Administration/Coding)
Jason A. Dominitz, MD, MHS, AGAF (Gastroenterology) VA Puget Sound Health Care System, Seattle, WA
Ira L. Flax, MD, FACG (Gastroenterology) American College of Gastroenterology, Houston, TX
Karen E. Hall, MD, PhD (Geriatrics) University of Michigan HS, Ann Arbor, MI
Robert Haskey, MD, FACS (General Surgery, Health Plan representative)
Brian C. Jacobson, MD, MPH (Gastroenterology) ASGE, Needham, MA
David Lieberman, MD (Gastroenterology)
Klaus Mergener, MD, PhD, CPE, FACP, FACG, FASGE, FACPE (Gastroenterology) Tacoma, WA
Bret Petersen, MD, FASGE (Gastroenterology), Rochester, MN
Irving M. Pike, MD, FACG (Gastroenterology), Virginia Beach, VA
Bart Pope, MD (Family Medicine)
Harry Sarles, MD, FACG (Gastroenterology)

Kay Schwebke, MD, MPH (Internal Medicine, Infectious Diseases & Medical Informatics)
OptumInsight, Eden Prairie, MN
Tom Lynn, MD (Medical Informatics, Methodology)
Emily E. Volk, MD, FCAP (Pathology) San Antonio, TX
Michael Weinstein, MD (Gastroenterology) Chevy Chase, MD

2b2.3. What were the statistical results from validity testing? (*e.g., correlation; t-test, ANOVA*)

The aforementioned expert panel was used to systematically assess face validity of the measure. They were asked to rate their agreement with the following statement:

"The scores obtained from the measure as specified will accurately differentiate quality across providers."

Scale 1-5, where 1=Strongly Disagree; 3=Neither Disagree nor Agree; 5=Strongly Agree

The results of the expert panel rating of the validity statement for Measure 658 were as follows: N = 14; Mean rating = 4.36 and 92.86% of respondents either agree or strongly agree that this measure can accurately distinguish good and poor quality.

Frequency Distribution of Ratings
1 - 1 (Strongly Disagree)
2 - 0
3 – 0 (Neither Agree nor Disagree)
4 - 5
5 - 8 (Strongly Agree)

2b2.4. What is your interpretation of the results in terms of demonstrating validity? (i.*e., what do the results mean and what are the norms for the test conducted?*)

The results of the expert panel rating of the validity statement for Measure 658 were as follows: N = 14; Mean rating = 4.36 and 92.86% of respondents either agree or strongly agree that this measure can accurately distinguish good and poor quality.

These results demonstrate that Measure 658 has high face validity.

2b3. EXCLUSIONS ANALYSIS

NA ☐ no exclusions — *skip to #2b5*

2b3.1. Describe the method of testing exclusions and what it tests (*describe the steps—do not just name a method; what was tested, e.g., whether exclusions affect overall performance scores; what statistical analysis was used*)

Exceptions were determined based on reported characteristics of the endoscopy. Some of the possible reasons for a denominator exception could be: inadequate bowel prep; incomplete colon examination; above average patient risk; complications arising during colonoscopy.

The examples are congruent with guidance from the ASGE in their 2006 guidelines for colorectal cancer screening and surveillance which indicate that "the completeness of the examination and the quality of the preparation should be taken into account for the timing of subsequent examinations."

2b3.2. What were the statistical results from testing exclusions? (*include overall number and percentage of individuals excluded, frequency distribution of exclusions across measured entities, and impact on performance measure scores*)

Data 1

For the 177 physicians that had all the required data elements and met the minimum number of quality reporting events (10) for inclusion in the reliability analysis, there were a total of 17,640 quality reporting events. 3,274 of the events were considered exceptions for an exception rate of 18%. The average number of exceptions for 177 physicians included is 18.5. The range of exception rates for physicians included 44% to 0%.

Data 2

For the 20 physicians that had all the required data elements and met the minimum number of quality reporting events (10) for inclusion in the reliability analysis, there were a total of 2,230 quality reporting events. 319 of the events were considered exceptions for an exception rate of 0.14. The average number of exceptions for 20 physicians included is 15.95. The range of exception rates for physicians included 85% to 1%.

2b3.3. What is your interpretation of the results in terms of demonstrating that exclusions are needed to prevent unfair distortion of performance results? (*i.e., the value outweighs the burden of increased data collection and analysis. Note: **If patient preference is an exclusion**, the measure must be specified so that the effect on the performance score is transparent, e.g., scores with and without exclusion*)

The rates of exceptions are consistent with research that has suggested that approximately 25% of patients undergoing colonoscopy have poor bowel preparation.(1, 2)

Reference

1. Van Dongen M. Enhancing bowel preparation for colonoscopy: an integrative review. Gastroenterol Nurs. 2012 Jan;35(1):36-44.
2. Lebwohl B, Wang TC, Neugut AI. Socioeconomic and other predictors of colonoscopy preparation quality. Dig Dis Sci. 2010 Jul;55(7):2014-20. Epub 2010 Jan 16.

2b5. IDENTIFICATION OF STATISTICALLY SIGNIFICANT & MEANINGFUL DIFFERENCES IN PERFORMANCE

2b5.1. Describe the method for determining if statistically significant and clinically/practically meaningful differences in performance measure scores among the measured entities can be identified (*describe the steps—do not just name a method; what statistical analysis was used)*

Measures of central tendency, variability, and dispersion were calculated.

2b5.2. What were the statistical results from testing the ability to identify differences in performance measure scores across measured entities? (*at a minimum, the distribution of performance measure scores for the measured entities by decile/quartile, mean, std dev; preferably also number and percentage statistically different from mean or some benchmark, different form expected, etc.*)

Data 1

Based on the sample of 177 included physicians, the mean performance rate is 0.5343, the median performance rate is 0.64 and the mode is 0.0. The standard deviation is 0.31 The range of the performance rate is 1.0, with a minimum rate of 0.00 and a maximum rate of 1.00. The interquartile range is 0.48. The 75th percentile is 0.78 and the 25th percentile is 0.3.

Data 2

Based on the sample of 20 included physicians, the mean performance rate is 0.3148, the median performance rate is 0.24 and the mode is 0. The standard deviation is 0.34 The range of the performance rate is 0.89, with a minimum rate of 0.00 and a maximum rate of 0.89. The interquartile range is 0.68. The 75th percentile is 0.68 and the 25th percentile is 0.0.

2b5.3. What is your interpretation of the results in terms of demonstrating the ability to identify statistically significant and clinically/practically meaningful differences in performance across measured entities? (i.e., *what do the results mean and what are the norms for the test conducted?*)

Data 1

The range of performance from 0.00 to 1.00 suggests there's clinically meaningful variation across physicians' performance.

Data 2

The range of performance from 0.00 to 0.89 suggests there's clinically meaningful variation across physicians' performance.

AMA-PCPI Endoscopy and Polyp Surveillance Measures:
Crosswalk from original NQF-endorsed measure data elements to eMeasure data elements

NQF 0658- Endoscopy and Polyp Surveillance:
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Data Element	**Original Measure Specifications (for administrative claims only)**	**Revised Measure eSpecifications (for use in EHRs)**
Screening colonoscopy	G-Code G0121 CPT 45378	G-Code G0121 CPT 45378 CPT 44388 (inclusion recommended by expert work group) SNOMED-CT 444783004 (concept for screening colonoscopy)
Malignanat Neoplasms Screening of Colon	N/A (was not included in original measure)	ICD-9 V76.51 ICD-10 Z12.11
Follow up Interval	CPT II 0528F	SNOMED-CT 183616001 (concept for follow up interval, arranged)
Above average risk	CPT II with modifier 0528F-1P	N/A (value set removed)
Inadequate bowel prep	CPT II with modifier 0528F-1P	SNOMED-CT 413261003 (concept for inadequate bowel prep)
Medical reason	CPT II with modifier 0528F-1P	Medical reason value set (standard value set)

AMA-PCPI Endoscopy and Polyp Surveillance Measures:
Crosswalk from original NQF-endorsed measure data elements to eMeasure data elements

NQF 0658- Endoscopy and Polyp Surveillance:
Colonoscopy Interval for Patients with a History of Adenomatous Polyps Avoidance of Inappropriate Use

Data Element	Original Measure Specifications (for administrative claims only)	Revised Measure eSpecifications (for use in EHRs)
Colonoscopy	CPT Codes or G-Codes: 44388, 44389, 44392, 44393, 44394, 45355, 45378, 45380, 45381, 45383, 45384, 45385, G0105	All codes from Original submission PLUS addition of relevant SNOMED colonoscopy concepts
Colonic Polyps	ICD-9-CM diagnosis code: V12.72	ICD-10-CM diagnosis codes: D12.2, D12.3, D12.4, D12.5, D12.6, D12.7 and SNOMED concept 70921007 (ICD-9-CM not included because it does not capture adenomatous polyps)
Adenomatous polyp of colon	Coded with V12.72 (see above)	SNOMED concept 428054006
Colonoscopy, high risk screening Procedure	G-code G0121 (ERROR)	HCPCS G0105 (corrected from earlier submission)
Inadequate bowel prep	CPT II with modifier 0529F-1P	SNOMED-CT 413261003 (concept for inadequate bowel prep)
Incomplete Procedure	CPT II with modifier 0529F-1P	SNOMED-CT 396908001 (concept for incomplete procedure)
Medical reason	CPT II with modifier 0529F-1P	Medical reason value set (standard/universal value set for eMeasures)
System reason	CPT II with modifier 0529F-3P	System reason value set (standard/universal value set for eMeasures)
High risk for colon cancer	CPT II with modifier 0529F-1P	N/A (value set replaced with four individual value sets for the specific medical conditions: crohn's disease, ulcerative colitis, lower gastrointestinal bleeding, personal or family history of colon cancer)
Crohn's Disease	N/A (was not included in original measure)	ICD-9-CM, ICD-10-CM and SNOMED-CT diagnosis codes for Crohn's Disease
Ulcerative Colitis	N/A (was not included in original measure)	ICD-9-CM, ICD-10-CM and SNOMED-CT diagnosis codes for Ulcerative Colitis
Lower Gastrointestinal Bleeding	N/A (was not included in original measure)	ICD-9-CM, ICD-10-CM and SNOMED-CT diagnosis codes for Lower Gastrointestinal Bleeding
Personal or Family History of Colon Cancer	N/A (was not included in original measure)	ICD-9-CM, ICD-10-CM and SNOMED-CT diagnosis codes for Personal or Family History of Colon Cancer

Summary of Changes Made to PCPI eSpecifications
NQF 0658 & NQF 0659
Submitted to NQF May 31, 2013

	NQF Measure #	Change Made to Measure	Original Submission	Revised Submission Includes	Rationale
NQF 0658-Endoscopy and Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients					
1.	0658	Removed "above average risk for colon cancer" as a valid exception.	Denominator exceptions included: medical reason inadequate bowel prep, above average risk for colon cancer	Denominator exceptions now include: -medical reason -inadequate bowel prep	Due to the addition of ICD9/ICD10 diagnosis codes, (see below), the "above average risk" medical reason exception for "above average risk" is no longer needed. Population has been defined to only include those with normal risk.
2.	0658	IPP now includes procedure and diagnosis codes	Initial Patient Population (IPP): Screening Colonoscopy SNOMED, HCPCS and CPT codes	Initial Patient Population: addition of ICD9/ICD10 diagnostic codes V76.51 and Z12.11 (Malignant neoplasms screening of colon)	The updated list of codes more succinctly reflects the intended population for the measure. By including the "V" and "Z" codes, the denominator is appropriately limited to patients undergoing average risk screening.
3.	0658	Revised Screening Colonoscopy Value Set	Included procedures that may not be performed for screening colonoscopies	Only includes G Code G0121, CPT 44388, 45378; and SNOMED-CT for screening colonoscopy.	Expert work group discussed; agreed that initial list was too broad.
NQF 0659-Endoscopy and Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use					
4.	0659	High risk for colon cancer value set divided into 4 distinct value sets: -Crohn's disease -ulcerative colitis	Denominator exceptions: patient with high risk for colon cancer, inadequate bowel prep, incomplete procedure,	Denominator exceptions: Value sets for 4 high risk conditions: Crohn's disease Ulcerative colitis Lower gastrointestinal bleeding	The conditions and diseases that cause a patient to be at high risk for colon cancer were identified by the expert workgroup and four new value sets were created to replace the current (and more broad) "high

	NQF Measure #	Change Made to Measure	Original Submission	Revised Submission Includes	Rationale
		-lower gastrointestinal bleeding -personal or family history of colon cancer	removal of >10 adenomas, other medical reason	Personal or family history of colon cancer Also includes: inadequate bowel prep, incomplete procedure, removal of >10 adenomas, other medical reason	risk for colon cancer" exception value set. Several diagnoses codes previously included but did not fit into these categories were removed from the measure.
5.	0659	Replaced G0121 with G0105	G0121 incorrectly included in value set	G0105- Colorectal cancer screening; colonoscopy on individual at high risk	Correction to submission.

Text Description for PCPI eSpecification

Clinical Topic	**Endoscopy and Polyp Surveillance**
Measure Title	**Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients**
Measure #	**ENDO-1/PQRS #320/NQF #0658**
Measure Description	Percentage of patients aged 50 years 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 their colonoscopy report
Measurement Period	12 consecutive months
Initial Patient Population	All patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy
Denominator Statement	Equals Initial Patient Population
Denominator Exceptions	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, inadequate prep, other medical reasons)
Numerator Statement	Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report
Denominator Exclusions	There are no valid Denominator Exclusions

Endoscopy and Polyp Surveillance
Data Requirements Table for PCPI eSpecification

Endoscopy and Polyp Surveillance
Data Requirements Table for PCPI eSpecification

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Measure Component	QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Supplemental Data Elements	Individual Characteristic	Patient Characteristic	ONC Administrative Sex	HL7 (2.16.840.1.113883.5.1)	2.16.840.1.113762.1.4.1	during measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
	Individual Characteristic	Patient Characteristic	Race	CDC	2.16.840.1.114222.4.11.836	during measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
	Individual Characteristic	Patient Characteristic	Ethnicity	CDC	2.16.840.1.114222.4.11.837	during measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
	Individual Characteristic	Patient Characteristic	Preferred Language	CDC	2.16.840.1.114222.4.11.831	during measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
	Individual Characteristic	Patient Characteristic	Payer	Source of Payment Typology	2.16.840.1.113883.221.5	during measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Initial Patient Population	Measure Timing	n/a	Measurement Start Date	n/a	n/a	TBD by Measure Implementer	
	Measure Timing	n/a	Measurement End Date	n/a	n/a	TBD by Measure Implementer	
	Individual Characteristic	Patient Characteristic	Birth Date	LOINC	2.16.840.1.113883.3.560.100.4	starts before the start of measurement period	
	Individual Characteristic	Patient Characteristic	age	Calculation	n/a	starts before the start of measurement period	Measurement start date minus Birth Date must be greater than or equal to 50 years.
	Procedure	Procedure, Result	Screening Colonoscopy [Occurrence A]	GROUPING CPT HCPCS SNOMED-CT	600001 600010 600011 600012	during measurement period	
	Diagnosis	Diagnosis, Active	Malignant Neoplasms Screening of Colon	GROUPING ICD-9-CM ICD-10-CM	600003 600013 600014	during measurement period	
	Attribute	Attribute: Status	Final Report	GROUPING SNOMED-CT	2.16.840.1.113883.3.526.3.1201 2.16.840.1.113883.3.526.2.796	n/a	This attribute is applied to the grouping value set titled "Screening Colonoscopy"
Denominator	Equals Initial Patient Population						
Denominator Exclusions	There are no valid denominator exclusions						
Numerator	Procedure	Procedure, Result	Screening Colonoscopy [Occurrence A]	GROUPING CPT HCPCS SNOMED-CT	600001 600010 600011 600012	during measurement period	
	Attribute	Attribute: Status	Final Report	GROUPING SNOMED-CT	2.16.840.1.113883.3.526.3.1201 2.16.840.1.113883.3.526.2.796	n/a	This attribute is applied to the value set titled "Screening Colonoscopy"
	Procedure	Procedure, Result	Follow-Up Interval	GROUPING SNOMED-CT	600002 600015	n/a	This attribute is applied to the value set titled "Screening Colonoscopy" to indicate that documentation of a 'follow-up interval' of at least 10 years must be found in the 'Final Report'
Denominator Exceptions	Procedure	Procedure, Result	Screening Colonoscopy [Occurrence A]	GROUPING CPT HCPCS SNOMED-CT	600001 600010 600011 600012	during measurement period	
	Attribute	Attribute: Status	Final Report	GROUPING SNOMED-CT	2.16.840.1.113883.3.526.3.1201 2.16.840.1.113883.3.526.2.796	n/a	This attribute is applied to the value set titled "Screening Colonoscopy" to indicate that the result must be found in the 'Final Report'
	Attribute	Attribute: Result	Inadequate Bowel Preparation	GROUPING SNOMED-CT	2.16.840.1.113883.3.526.3.1498 2.16.840.1.113883.3.526.2.791	starts before or during [Procedure, Result]	This attribute is applied to the value set titled "Screening Colonoscopy" to indicate that the 'Inadequate Bowel Preparation' must be found in the 'Final Report'
	Attribute	Attribute: Negation Rationale	Medical Reason	GROUPING SNOMED-CT	2.16.840.1.113883.3.526.3.1007 2.16.840.1.113883.3.526.2.313	starts before or during [Procedure, Result]	This attribute is applied to the value set titled "Screening Colonoscopy" to indicate that a medical reason for the 'Follow-Up Interval' being less than 10 years must be found in the 'Final Report'

PCPI eSpecification

Measure Logic for Endoscopy and Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
Measure Description: Percentage of patients aged 50 years 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 their colonoscopy report
Measurement Period: 12 Consecutive Months
PCPI Measure #: ENDO-1/PQRS #320/NQF #0658

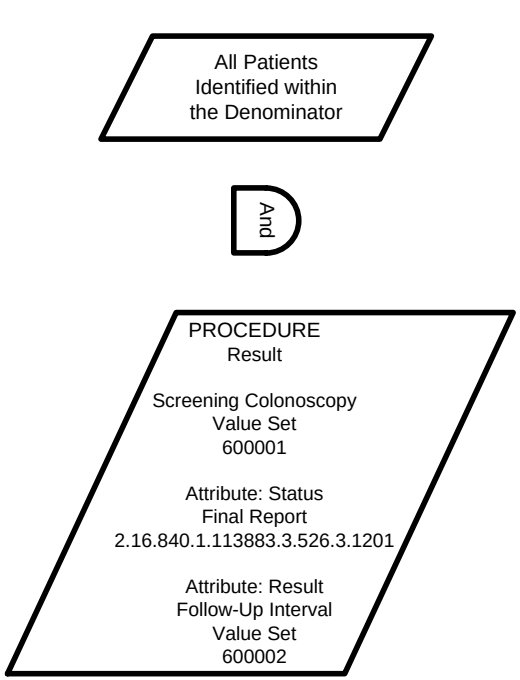
Supplemental Data Elements (SDE)	Identify Patients in Initial Patient Population (IPP)	Identify Patients in Denominator (D)	Identify Patients in Denominator Exclusion (EXCL)
PATIENT CHARACTERISTIC ONC Administrative Sex 2.16.840.1.113762.1.4.1 PATIENT CHARACTERISTIC Race 2.16.840.1.114222.4.11.836 PATIENT CHARACTERISTIC Ethnicity 2.16.840.1.114222.4.11.837 PATIENT CHARACTERISTIC Preferred Language 2.16.840.1.114222.4.11.831 PATIENT CHARACTERISTIC Payer 2.16.840.1.113883.221.5	PATIENT CHARACTERISTIC Patient Age >= 50 Years And DIAGNOSIS Active Malignant Neoplasms Screening of Colon Value Set 600003 And PROCEDURE Result Screening Colonoscopy Value Set 600001 Attribute: Result Final Report 2.16.840.1.113883.3.526.3.1201	All Patients Identified within the Initial Patient Population	No Valid Denominator Exclusions for this Measure

See Data Requirements Table for timing constraints and relationship between data elements.

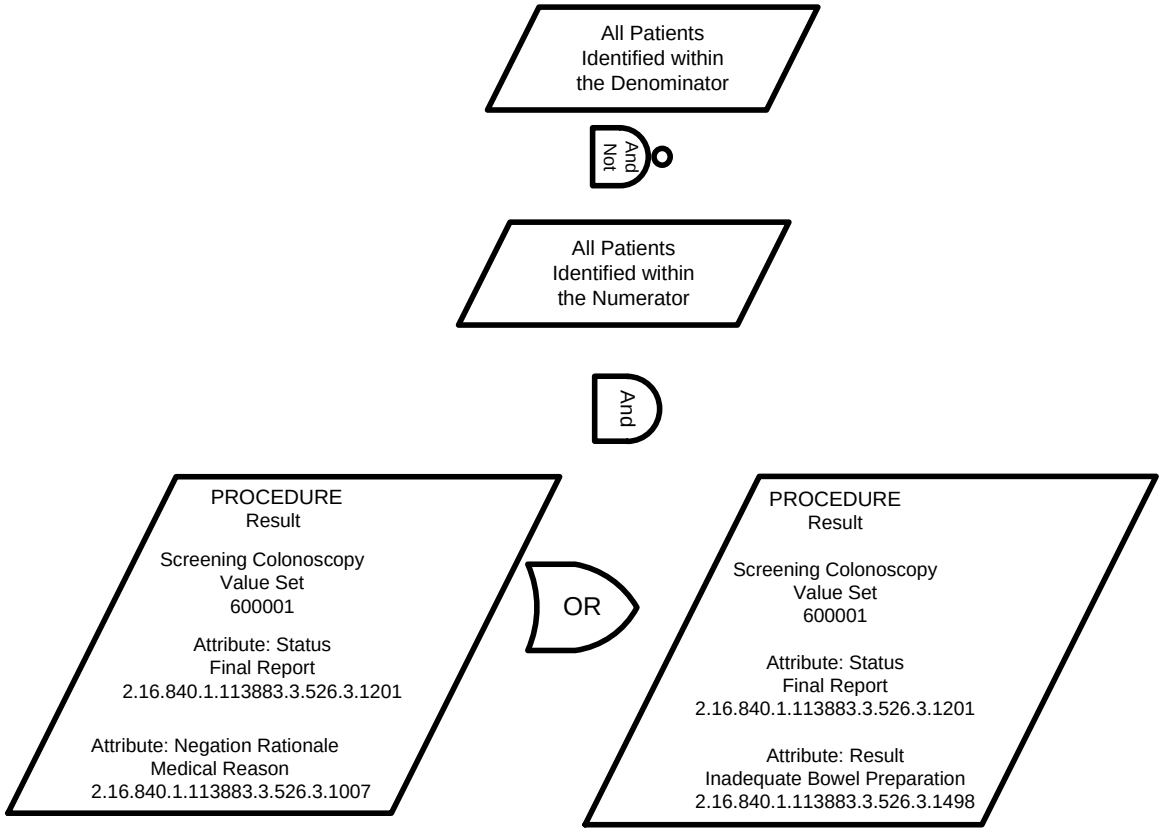
PCPI eSpecification

Measure Logic for Endoscopy and Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
Measure Description: Percentage of patients aged 50 years 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 their colonoscopy report
Measurement Period: 12 Consecutive Months
PCPI Measure #: ENDO-1/PQRS #320/NQF #0658

Identify Patients in Numerator (N)



Identify Patients who have valid Denominator Exceptions * (EXCEP)



See Data Requirements Table for timing constraints and relationship between data elements.

*Coded examples for exceptions are NOT intended to be an exhaustive list. Exceptions will vary for each patient and situation.

Endoscopy and Polyp Surveillance
Supplemental Value Sets for PCPI eSpecification

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
National Library of Medicine	2.16.840.1.113762.1.4.1	ONC Administrative Sex	Individual Characteristic	Administrative Sex	HL7 v2.5	F	Female
National Library of Medicine	2.16.840.1.113762.1.4.1	ONC Administrative Sex	Individual Characteristic	Administrative Sex	HL7 v2.5	M	Male
National Library of Medicine	2.16.840.1.113762.1.4.1	ONC Administrative Sex	Individual Characteristic	Administrative Sex	HL7 v2.5	U	Unknown
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	1	MEDICARE
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	2	MEDICAID
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3	OTHER GOVERNMENT (Federal/State/Local) (excluding Department of Corrections)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	4	DEPARTMENTS OF CORRECTIONS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	5	PRIVATE HEALTH INSURANCE
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	6	BLUE CROSS/BLUE SHIELD
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	7	MANAGED CARE, UNSPECIFIED(to be used only if one can't distinguish public from private)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	8	NO PAYMENT from an Organization/Agency/Program/Private Payer Listed
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	9	MISCELLANEOUS/OTHER
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	11	Medicare (Managed Care)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	12	Medicare (Non-managed Care)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	19	Medicare Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	21	Medicaid (Managed Care)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	22	Medicaid (Non-managed Care Plan)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	23	Medicaid/SCHIP
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	24	Medicaid Applicant
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	25	Medicaid - Out of State
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	29	Medicaid Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	31	Department of Defense
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32	Department of Veterans Affairs
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	33	Indian Health Service or Tribe
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	34	HRSA Program
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	35	Black Lung
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	36	State Government
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	37	Local Government
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	38	Other Government (Federal, State, Local not specified)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	39	Other Federal
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	41	Corrections Federal
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	42	Corrections State
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	43	Corrections Local
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	44	Corrections Unknown Level
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	51	Managed Care (Private)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	52	Private Health Insurance - Indemnity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	53	Managed Care (private) or private health insurance (indemnity), not otherwise specified
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	54	Organized Delivery System
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	55	Small Employer Purchasing Group
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	59	Other Private Insurance
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	61	BC Managed Care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	62	BC Indemnity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	63	BC (Indemnity or Managed Care) - Out of State
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	64	BC (Indemnity or Managed Care) - Unspecified
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	69	BC (Indemnity or Managed Care) - Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	71	HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	72	PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	73	POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	79	Other Managed Care, Unknown if public or private
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	81	Self-pay
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	82	No Charge

Endoscopy and Polyp Surveillance
Supplemental Value Sets for PCPI eSpecification

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	83	Refusal to Pay/Bad Debt
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	84	Hill Burton Free Care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	85	Research/Donor
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	89	No Payment, Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	91	Foreign National
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	92	Other (Non-government)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	93	Disability Insurance
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	94	Long-term Care Insurance
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	95	Worker's Compensation
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	96	Auto Insurance (no fault)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	98	Other specified (includes Hospice - Unspecified plan)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	99	No Typology Code available for payment source
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	111	Medicare HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	112	Medicare PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	113	Medicare POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	119	Medicare Managed Care Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	121	Medicare FFS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	122	Drug Benefit
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	123	Medicare Medical Savings Account (MSA)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	129	Medicare Non-managed Care Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	211	Medicaid HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	212	Medicaid PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	213	Medicaid PCCM (Primary Care Case Management)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	219	Medicaid Managed Care Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	311	TRICARE (CHAMPUS)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	312	Military Treatment Facility
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	313	Dental --Stand Alone
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	321	Veteran care--Care provided to Veterans
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	322	Non-veteran care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	331	Indian Health Service - Regular
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	332	Indian Health Service - Contract
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	333	Indian Health Service - Managed Care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	334	Indian Tribe - Sponsored Coverage
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	341	Title V (MCH Block Grant)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	342	Migrant Health Program
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	343	Ryan White Act
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	349	Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	361	State SCHIP program (codes for individual states)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	362	Specific state programs (list/ local code)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	369	State, not otherwise specified (other state)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	371	Local - Managed care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	372	FFS/Indemnity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	379	Local, not otherwise specified (other local, county)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	381	Federal, State, Local not specified managed care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	382	Federal, State, Local not specified - FFS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	389	Federal, State, Local not specified - Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	511	Commercial Managed Care - HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	512	Commercial Managed Care - PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	513	Commercial Managed Care - POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	514	Exclusive Provider Organization
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	515	Gatekeeper PPO (GPPO)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	519	Managed Care, Other (non HMO)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	521	Commercial Indemnity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	522	Self-insured (ERISA) Administrative Services Only (ASO) plan
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	523	Medicare supplemental policy (as second payer)

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	529	Private health insurance—other commercial Indemnity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	611	BC Managed Care - HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	612	BC Managed Care - PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	613	BC Managed Care - POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	619	BC Managed Care - Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	821	Charity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	822	Professional Courtesy
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	823	Hispanic or Latino
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	951	Worker's Comp HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	953	Worker's Comp Fee-for-Service
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	954	Worker's Comp Other Managed Care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	959	Worker's Comp, Other unspecified
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3111	TRICARE Prime--HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3112	TRICARE Extra--PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3113	TRICARE Standard - Fee For Service
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3114	TRICARE For Life--Medicare Supplement
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3115	TRICARE Reserve Select
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3116	Uniformed Services Family Health Plan (USFHP) -- HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3119	Department of Defense - (other)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3121	Enrolled Prime--HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3122	Non-enrolled Space Available
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3123	TRICARE For Life (TFL)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3211	Direct Care--Care provided in VA facilities
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3212	Indirect Care--Care provided outside VA facilities
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3221	Civilian Health and Medical Program for the VA (CHAMPVA)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3222	Spina Bifida Health Care Program (SB)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3223	Children of Women Vietnam Veterans (CWVV)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3229	Other non-veteran care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3711	HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3712	PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3713	POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3811	Federal, State, Local not specified - HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3812	Federal, State, Local not specified - PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3813	Federal, State, Local not specified - POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3819	Federal, State, Local not specified - not specified managed care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	9999	Unavailable / Unknown
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32121	Fee Basis
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32122	Foreign Fee/Foreign Medical Program(FMP)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32123	Contract Nursing Home/Community Nursing Home
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32124	State Veterans Home
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32125	Sharing Agreements
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32126	Other Federal Agency
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	1002-5	American Indian or Alaska Native
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2028-9	Asian
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2054-5	Black or African American
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2076-8	Native Hawaiian or Other Pacific Islander
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2106-3	White
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2131-1	Other Race
CDC NCHS	2.16.840.1.114222.4.11.837	Ethnicity	Individual Characteristic	CDC	1.0	2135-2	Hispanic or Latino
CDC NCHS	2.16.840.1.114222.4.11.837	Ethnicity	Individual Characteristic	CDC	1.0	2186-5	Not Hispanic or Latino
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	abk	Abkhazian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ace	Achinese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ach	Acoli
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ada	Adangme
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ady	Adyghe; Adygei

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	aar	Afar
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	afh	Afrihili
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	afr	Afrikaans
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	afa	Afro-Asiatic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ain	Ainu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	aka	Akan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	akk	Akkadian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	alb	Albanian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ale	Aleut
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	alg	Algonquian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tut	Altaic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	amh	Amharic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	anp	Angika
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	apa	Apache languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ara	Arabic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arg	Aragonese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arp	Arapaho
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arw	Arawak
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arm	Armenian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rup	Aromanian; Arumanian; Macedo-Romanian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	art	Artificial (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	asm	Assamese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ast	Asturian; Bable; Leonese; Asturleonese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ath	Athapascan languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	aus	Australian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	map	Austronesian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ava	Avaric
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ave	Avestan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	awa	Awadhi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	aym	Aymara
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	aze	Azerbaijani
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ban	Balinese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bat	Baltic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bal	Baluchi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bam	Bambara
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bai	Bamileke languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bad	Banda languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bnt	Bantu (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bas	Basa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bak	Bashkir
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	baq	Basque
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	btk	Batak languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bej	Beja; Bedawiyet
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bel	Belarusian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bem	Bemba
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ben	Bengali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ber	Berber (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bho	Bhojpuri
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bih	Bihari
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bik	Bikol
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bin	Bini; Edo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bis	Bislama
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	byn	Blin; Bilin
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zbl	Blissymbols; Blissymbolics; Bliss
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nob	Bokmål, Norwegian; Norwegian Bokmål

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bos	Bosnian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bra	Braj
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bre	Breton
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bug	Buginese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bul	Bulgarian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bua	Buriat
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bur	Burmese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cad	Caddo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cat	Catalan; Valencian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cau	Caucasian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ceb	Cebuano
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cel	Celtic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cai	Central American Indian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	khm	Central Khmer
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chg	Chagatai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cmc	Chamic languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cha	Chamorro
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	che	Chechen
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chr	Cherokee
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chy	Cheyenne
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chb	Chibcha
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nya	Chichewa; Chewa; Nyanja
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chi	Chinese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chn	Chinook jargon
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chp	Chipewyan; Dene Suline
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cho	Choctaw
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chu	Church Slavic; Old Slavonic; Church Slavonic; Old Bulgarian; Old Church Slavonic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chk	Chuukese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chv	Chuvash
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nwc	Classical Newari; Old Newari; Classical Nepal Bhasa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	syc	Classical Syriac
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cop	Coptic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cor	Cornish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cos	Corsican
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cre	Cree
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mus	Creek
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	crp	Creoles and pidgins (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cpe	Creoles and pidgins, English based (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cpf	Creoles and pidgins, French-based (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cpp	Creoles and pidgins, Portuguese-based (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	crh	Crimean Tatar; Crimean Turkish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hrv	Croatian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cus	Cushitic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cze	Czech
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dak	Dakota
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dan	Danish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dar	Dargwa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	del	Delaware
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	din	Dinka
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	div	Divehi; Dhivehi; Maldivian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	doi	Dogri
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dgr	Dogrib
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dra	Dravidian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dua	Duala

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dum	Dutch, Middle (ca.1050-1350)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dut	Dutch; Flemish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dyu	Dyula
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dzo	Dzongkha
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	frs	Eastern Frisian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	efi	Efik
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	egy	Egyptian (Ancient)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	eka	Ekajuk
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	elx	Elamite
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	eng	English
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	enm	English, Middle (1100-1500)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ang	English, Old (ca.450-1100)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	myv	Erzya
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	epo	Esperanto
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	est	Estonian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ewe	Ewe
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ewo	Ewondo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fan	Fang
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fat	Fanti
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fao	Faroese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fij	Fijian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fil	Filipino; Pilipino
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fin	Finnish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fiu	Finno-Ugrian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fon	Fon
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fre	French
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	frm	French, Middle (ca.1400-1600)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fro	French, Old (842-ca.1400)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fur	Friulian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ful	Fulah
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gaa	Ga
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gla	Gaelic; Scottish Gaelic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	car	Galibi Carib
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	glg	Galician
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lug	Ganda
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gay	Gayo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gba	Gbaya
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gez	Geez
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	geo	Georgian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ger	German
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gmh	German, Middle High (ca.1050-1500)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	goh	German, Old High (ca.750-1050)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gem	Germanic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gil	Gilbertese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gon	Gondi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gor	Gorontalo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	got	Gothic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	grb	Grebo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	grc	Greek, Ancient (to 1453)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gre	Greek, Modern (1453-)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	grn	Guarani
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	guj	Gujarati
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gwi	Gwich'in
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hai	Haida
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hat	Haitian; Haitian Creole

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hau	Hausa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	haw	Hawaiian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	heb	Hebrew
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	her	Herero
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hil	Hiligaynon
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	him	Himachali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hin	Hindi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hmo	Hiri Motu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hit	Hittite
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hmn	Hmong
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hun	Hungarian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hup	Hupa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	iba	Iban
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ice	Icelandic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ido	Ido
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ibo	Igbo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ijo	Ijo languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ilo	Iloko
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	smn	Inari Sami
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	inc	Indic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ine	Indo-European (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ind	Indonesian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	inh	Ingush
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ina	Interlingua (International Auxiliary Language Association)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ile	Interlingue; Occidental
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	iku	Inuktitut
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ipk	Inupiaq
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ira	Iranian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gle	Irish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mga	Irish, Middle (900-1200)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sga	Irish, Old (to 900)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	iro	Iroquoian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ita	Italian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	jpn	Japanese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	jav	Javanese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	jrb	Judeo-Arabic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	jpr	Judeo-Persian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kbd	Kabardian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kab	Kabyle
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kac	Kachin; Jingpho
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kal	Kalaallisut; Greenlandic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	xal	Kalmyk; Oirat
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kam	Kamba
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kan	Kannada
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kau	Kanuri
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	krc	Karachay-Balkar
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kaa	Kara-Kalpak
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	krl	Karelian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kar	Karen languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kas	Kashmiri
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	csb	Kashubian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kaw	Kawi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kaz	Kazakh
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kha	Khasi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	khi	Khoisan (Other)

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kho	Khotanese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kik	Kikuyu; Gikuyu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kmb	Kimbundu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kin	Kinyarwanda
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kir	Kirghiz; Kyrgyz
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tlh	Klingon; tlhIngan-Hol
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kom	Komi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kon	Kongo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kok	Konkani
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kor	Korean
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kos	Kosraean
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kpe	Kpelle
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kro	Kru languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kua	Kuanyama; Kwanyama
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kum	Kumyk
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kur	Kurdish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kru	Kurukh
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kut	Kutenai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lad	Ladino
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lah	Lahnda
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lam	Lamba
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	day	Land Dayak languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lao	Lao
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lat	Latin
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lav	Latvian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lez	Lezghian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lim	Limburgan; Limburger; Limburgish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lin	Lingala
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lit	Lithuanian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	jbo	Lojban
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nds	Low German; Low Saxon; German, Low; Saxon, Low
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dsb	Lower Sorbian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	loz	Lozi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lub	Luba-Katanga
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lua	Luba-Lulua
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lui	Luiseno
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	smj	Lule Sami
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lun	Lunda
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	luo	Luo (Kenya and Tanzania)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lus	Lushai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ltz	Luxembourgish; Letzeburgesch
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mac	Macedonian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mad	Madurese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mag	Magahi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mai	Maithili
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mak	Makasar
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mlg	Malagasy
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	may	Malay
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mal	Malayalam
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mlt	Maltese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mnc	Manchu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mdr	Mandar
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	man	Mandingo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mni	Manipuri
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mno	Manobo languages

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	glv	Manx
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mao	Maori
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arn	Mapudungun; Mapuche
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mar	Marathi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chm	Mari
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mah	Marshallese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mwr	Marwari
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mas	Masai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	myn	Mayan languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	men	Mende
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mic	Mi'kmaq; Micmac
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	min	Minangkabau
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mwl	Mirandese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	moh	Mohawk
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mdf	Moksha
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mol	Moldavian; Moldovan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lol	Mongo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mon	Mongolian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mkh	Mon-Khmer (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mos	Mossi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mul	Multiple languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mun	Munda languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nah	Nahuatl languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nau	Nauru
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nav	Navajo; Navaho
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nde	Ndebele, North; North Ndebele
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nbl	Ndebele, South; South Ndebele
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ndo	Ndonga
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nap	Neapolitan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	new	Nepal Bhasa; Newari
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nep	Nepali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nia	Nias
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nic	Niger-Kordofanian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ssa	Nilo-Saharan (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	niu	Niuean
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nqo	N'Ko
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zxx	No linguistic content; Not applicable
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nog	Nogai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	non	Norse, Old
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nai	North American Indian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	frr	Northern Frisian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sme	Northern Sami
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nor	Norwegian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nno	Norwegian Nynorsk; Nynorsk, Norwegian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nub	Nubian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nym	Nyamwezi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nyn	Nyankole
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nyo	Nyoro
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nzi	Nzima
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	oci	Occitan (post 1500); Provençal
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arc	Official Aramaic (700-300 BCE); Imperial Aramaic (700-300 BCE)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	oji	Ojibwa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ori	Oriya
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	orm	Oromo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	osa	Osage

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	oss	Ossetian; Ossetic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	oto	Otomian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pal	Pahlavi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pau	Palauan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pli	Pali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pam	Pampanga; Kapampangan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pag	Pangasinan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pan	Panjabi; Punjabi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pap	Papiamento
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	paa	Papuan (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nso	Pedi; Sepedi; Northern Sotho
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	per	Persian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	peo	Persian, Old (ca.600-400 B.C.)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	phi	Philippine (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	phn	Phoenician
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pon	Pohnpeian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pol	Polish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	por	Portuguese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pra	Prakrit languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pro	Provençal, Old (to 1500)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pus	Pushto; Pashto
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	que	Quechua
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	raj	Rajasthani
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rap	Rapanui
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rar	Rarotongan; Cook Islands Maori
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	qaa-qtz	Reserved for local use
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	roa	Romance (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rum	Romanian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	roh	Romansh
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rom	Romany
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	run	Rundi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rus	Russian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sal	Salishan languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sam	Samaritan Aramaic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	smi	Sami languages (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	smo	Samoan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sad	Sandawe
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sag	Sango
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	san	Sanskrit
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sat	Santali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	srd	Sardinian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sas	Sasak
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sco	Scots
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sel	Selkup
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sem	Semitic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	srp	Serbian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	srr	Serer
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	shn	Shan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sna	Shona
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	iii	Sichuan Yi; Nuosu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	scn	Sicilian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sid	Sidamo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sgn	Sign Languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bla	Siksika
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	snd	Sindhi

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sin	Sinhala; Sinhalese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sit	Sino-Tibetan (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sio	Siouan languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sms	Skolt Sami
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	den	Slave (Athapascan)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sla	Slavic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	slo	Slovak
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	slv	Slovenian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sog	Sogdian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	som	Somali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	son	Songhai languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	snk	Soninke
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wen	Sorbian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sot	Sotho, Southern
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sai	South American Indian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	alt	Southern Altai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sma	Southern Sami
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	spa	Spanish; Castilian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	srn	Sranan Tongo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	suk	Sukuma
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sux	Sumerian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sun	Sundanese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sus	Susu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	swa	Swahili
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ssw	Swati
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	swe	Swedish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gsw	Swiss German; Alemannic; Alsatian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	syr	Syriac
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tgl	Tagalog
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tah	Tahitian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tai	Tai (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tgk	Tajik
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tmh	Tamashek
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tam	Tamil
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tat	Tatar
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tel	Telugu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ter	Tereno
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tet	Tetum
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tha	Thai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tib	Tibetan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tig	Tigre
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tir	Tigrinya
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tem	Timne
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tiv	Tiv
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tli	Tlingit
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tpi	Tok Pisin
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tkl	Tokelau
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tog	Tonga (Nyasa)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ton	Tonga (Tonga Islands)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tsi	Tsimshian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tso	Tsonga
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tsn	Tswana
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tum	Tumbuka
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tup	Tupi languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tur	Turkish

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ota	Turkish, Ottoman (1500-1928)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tuk	Turkmen
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tvl	Tuvalu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tyv	Tuvinian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	twi	Twi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	udm	Udmurt
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	uga	Ugaritic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	uig	Uighur; Uyghur
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ukr	Ukrainian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	umb	Umbundu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mis	Uncoded languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	und	Undetermined
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hsb	Upper Sorbian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	urd	Urdu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	uzb	Uzbek
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	vai	Vai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ven	Venda
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	vie	Vietnamese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	vol	Volapük
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	vot	Votic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wak	Wakashan languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wal	Walamo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wln	Walloon
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	war	Waray
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	was	Washo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wel	Welsh
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fry	Western Frisian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wol	Wolof
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	xho	Xhosa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sah	Yakut
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	yao	Yao
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	yap	Yapese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	yid	Yiddish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	yor	Yoruba
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ypk	Yupik languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	znd	Zande languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zap	Zapotec
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zza	Zaza; Dimili; Dimli; Kirdki; Kirmanjki; Zazaki
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zen	Zenaga
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zha	Zhuang; Chuang
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zul	Zulu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zun	Zuni

Endoscopy and Polyp Surveillance
Value Sets for PCPI eSpecification

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set ID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600001	Screening Colonoscopy	Procedure	GROUPING	GROUPING	600010	"Screening Colonoscopy" CPT value set
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600001	Screening Colonoscopy	Procedure	GROUPING	GROUPING	600011	"Screening Colonoscopy" HCPCS value set
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600001	Screening Colonoscopy	Procedure	GROUPING	GROUPING	600012	"Screening Colonoscopy" SNOMED-CT value set
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600011	Screening Colonoscopy	Procedure	CPT	2013	45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600011	Screening Colonoscopy	Procedure	CPT	2013	44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600012	Screening Colonoscopy	Procedure	HCPCS	2012	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600012	Screening Colonoscopy	Procedure	SNOMED-CT	07/2012	444783004	screening colonoscopy (procedure)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600003	Malignant Neoplasms Screening of Colon	Procedure	GROUPING	GROUPING	600013	"Malignant Neoplasms Screening of Colon" ICD-9-CM value set
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600003	Malignant Neoplasms Screening of Colon	Procedure	GROUPING	GROUPING	600014	"Malignant Neoplasms Screening of Colon" ICD-10-CM value set
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600013	Malignant Neoplasms Screening of Colon	Procedure	ICD-9-CM	2013	V76.51	special screening for malignant neoplasms colon
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600014	Malignant Neoplasms Screening of Colon	Procedure	ICD-10-CM	2013	Z12.11	encounter for screening for malignant neoplasm of colon
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.3.1201	Final Report	Attribute	GROUPING	GROUPING	2.16.840.1.113883.3.526.2.796	"Final Report" SNOMED-CT value set
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.796	Final Report	Attribute	SNOMED-CT	07/2012	281321000	Final report (record artifact)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600002	Follow-Up Interval	Attribute	GROUPING	GROUPING	600015	"Follow-Up Interval" SNOMED-CT value set
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	600015	Follow-Up Interval	Attribute	SNOMED-CT	07/2012	183616001	follow up, arranged (finding)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.3.1498	Inadequate Bowel Preparation	Attribute	GROUPING	GROUPING	2.16.840.1.113883.3.526.2.791	"Inadequate Bowel Preparation" SNOMED-CT value set
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.791	Inadequate Bowel Preparation	Attribute	SNOMED-CT	07/2012	413261003	Inadequate bowel preparation (finding)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.3.1007	Medical Reason	Attribute	GROUPING	GROUPING	2.16.840.1.113883.3.526.2.313	"Medical reason" SNOMED-CT value set
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	31438003	drug resistance (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	35688006	complication of medical care (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	59037007	drug intolerance (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	62014003	adverse reaction to drug (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	79899007	drug interaction (finding)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	161590003	history of - drug allergy (situation)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	183932001	procedure contraindicated (situation)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	183964008	treatment not indicated (situation)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	183966005	drug treatment not indicated (situation)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	216952002	failure in dosage (event)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	266721009	absent response to treatment (situation)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	269191009	late effect of medical and surgical care complication (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	274512008	drug therapy discontinued (situation)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	371133007	treatment modification (procedure)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	397745006	medical contraindication (finding)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	407563006	treatment not tolerated (situation)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	410534003	not indicated (qualifier value)

Endoscopy and Polyp Surveillance
Value Sets for PCPI eSpecification

Measure #1 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Value Set Developer	Value Set ID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	410536001	contraindicated (qualifier value)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	416098002	drug allergy (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	416406003	procedure discontinued (situation)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	428119001	procedure not indicated (situation)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.313	Medical Reason	Attribute	SNOMED-CT	07/2011	445528004	treatment changed (situation)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.560.100.4	birth date	Individual characteristic	LOINC	2.36	21112-8	Date/Time of birth (TS)

Measure Performance Rate Calculation:

$$\frac{N}{(D - EXCL - EXCEP)} = \textbf{Performance Rate}$$

The PCPI strongly recommends that exception rates also be computed and reported alongside performance rates as follows:

Measure Exception Rate Calculation:

$$\frac{EXCEP}{(D - EXCL)} = \textbf{Exception Rate}$$

Exception Types:
EXCEP= E1 (Medical Exceptions) + E2 (Patient Exceptions) + E3 (System Exceptions)
For patients who have more than one valid exception, only one exception should be counted when calculating the exception rate.

Initial Patient Population (IPP)	Denominator (D)	Exclusions (EXCL)	Numerator (N)	Exceptions (EXCEP)
Definition: The group of patients that a set of performance measures is designed to address; usually focused on a specific clinical condition (e.g., coronary artery disease, asthma). For example, a patient aged 18 years and older with a diagnosis of CAD who has at least 2 visits during the measurement period.	**Definition:** The specific group of patients for inclusion in a specific performance measure based on specific criteria (e.g., patient's age, diagnosis, prior MI). In some cases, the denominator may be identical to the initial patient population.	**Definition:** The specific group of patients who should be subtracted from the measure population and denominator before determining if the numerator criteria are met.	**Definition:** The group of patients in the denominator for whom a process or outcome of care occurs (e.g., flu vaccine received).	**Definition:** The valid reasons why patients who are included in the denominator population did not receive a process or outcome of care (described in the numerator). Patients may have Exceptions for medical reasons (e.g., patient has an egg allergy so they did not receive flu vaccine); patient reasons (e.g., patient declined flu vaccine); or system reasons (e.g., patient did not receive flu Vaccine due to vaccine shortage). These cases are subtracted from the denominator population for the performance calculation, however the number of patients with valid exceptions should be calculated and reported. This group of patients constitutes the Exception reporting population – patients for whom the numerator was not achieved and a there is a valid Exception.
Find the patients who meet the Initial Patient Population criteria (IPP)	Find the patients who qualify for the Denominator (D): From the patients within the Patient Population criteria (IPP) select those people who meet Denominator selection criteria. (In some cases the IPP and D are identical).	Find the patients who qualify for the Exclusion: (EXCL): From the patients within the Denominator criteria, select those patients who meet Exclusion criteria. The patients meeting exclusion criteria should be removed from the Denominator.	Find the patients who qualify for the Numerator (N): From the patients within the Denominator (D) criteria, select those people who meet Numerator selection criteria. Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.	From the patients who did not meet the Numerator criteria, determine if the patient meets any criteria for the Exception (E1 + E2+E3). If they meet any criteria, they should be removed from the Denominator for performance calculation. As a point of reference, these cases are removed from the denominator population for the performance calculation, however the number of patients with valid exceptions should be calculated and reported.