To flourish under health-care reform, gastroenterologists must demonstrate high-value care. This portfolio is full of practical, easy-to-use information to help improve the care you provide patients and demonstrate your value to payors.
Dear Colleagues:

Gastroenterologists need to understand how to flourish in the rapidly changing world of health care. AGA is here to help. Enclosed you will find tools and resources to help you to understand and prepare for changes in reimbursement and health-care delivery, while maintaining a high-quality practice.

Some highlights from the toolkit:

- Review the episode payment framework for GERD to coordinate predetermined expected costs of a grouping, or “bundle,” of related health-care services with your payors. The model aims to reward you for identifying efficiency gains, effectively coordinating patient care and improving the quality of care provided.
- Use the GERD episode pathway to help develop your payment framework.
- Prepare for 2016 quality reporting by reviewing and understanding the AGA Qualified Clinical Data Registry performance measures.
- Ensure you are practicing evidence-based care by following our clinical decision support tools.

Sarah E. Streett, MD
Chair, Practice Management and Economics Committee

TABLE OF CONTENTS

4 An Episode Payment Framework for Gastroesophageal Reflux Disease
11 Outline of GERD Episode Pathway

2016 QUALITY REPORTING // 16

17 Digestive Health Recognition Program™
18 AGA 2016 Qualified Clinical Data Registry

2016 CLINICAL DECISION SUPPORT TOOLS // 21

22 Diagnosis and Management of Lynch Syndrome
23 The Role of Upper Gastrointestinal Biopsy to Evaluate Dyspepsia in the Adult Patient in the Absence of Visible Mucosal Lesions
24 Medical Management of Microscopic Colitis

PREVIOUSLY PUBLISHED CLINICAL DECISION SUPPORT TOOLS AND CLINICAL CARE PATHWAYS ARE AVAILABLE ONLINE AT www.gastro.org/guidelines:

- Early Detection of Colorectal Cancer
- Early Detection of Colorectal Cancer and Adenomatous Polyps
- Colonoscopy Surveillance After Cancer Resection
- Colorectal Cancer Surveillance
- Hepatitis B Reactivation
- Hepatitis C Screening and Evaluation
- Identification, Assessment and Initial Medical Treatment in Crohn’s Disease
- Identification, Assessment and Initial Medical Treatment of Ulcerative Colitis
- Management of Asymptomatic Neoplastic Pancreatic Cysts
- Treatment of Chronic Constipation
- Treatment for Normal Transit and Slow Transit Constipation
- Use of Biologic Drugs for Inflammatory Crohn’s Disease
- Treatment for Defecating Disorders
AN EPISODE PAYMENT FRAMEWORK FOR GASTROESOPHAGEAL REFUX DISEASE

As part of a continuing effort to help providers improve care quality under the Roadmap to the Future of GI, the American Gastroenterological Association created an episode payment model for the treatment of gastroesophageal reflux disease. An episode payment model is a method of reimbursement in which payments to health-care providers are related to the predetermined expected costs of a grouping, or “bundle,” of related health-care services. This model aims to reward providers for identifying efficiency gains, effectively coordinating patient care and improving the quality of care provided.

Included in the episode framework are patients with esophageal and extraesophageal syndromes, including those with Barrett’s esophagus with or without dysplasia, but excluding Barrett’s esophagus-associated adenocarcinoma. The episode addresses medical, as well as surgical, options for the treatment of GERD, but does not include the costs of surgery or the costs of complications requiring surgical intervention.

SYMPTOMATIC GASTROESOPHAGEAL REFUX DISEASE

Gastroesophageal reflux disease (GERD) is defined by the Montreal consensus as a condition that develops when the reflux of gastric content into the esophagus causes troublesome symptoms or complications.1,2,3

This includes the following symptom complexes:

- Typical reflux syndrome is defined by the presence of esophageal and extraesophageal syndromes, including those with Barrett’s esophagus with or without dysplasia, but excluding Barrett’s esophagus-associated adenocarcinoma. The episode addresses medical, as well as surgical, options for the treatment of GERD, but does not include the costs of surgery or the costs of complications requiring surgical intervention.

- Reflux chest pain syndrome is defined as episodes of chest pain that resemble ischemic cardiac pain, without accompanying heartburn or regurgitation.

- Extra-esophageal syndromes with proposed associations with GERD, including the following with or without typical GERD symptoms:
  - Pharyngitis
  - Sinusitis
  - Idiopathic pulmonary fibrosis
  - Recurrent otitis media

Population exclusions for the GERD episode include the following:

- Pediatric patients (younger than 18 years)
- A previously established diagnosis of:
  - Esophageal carcinoma
  - Anatomic esophageal anomaly
  - Eosphenal dysmotility disorder
  - Multiple endocrine neoplasia type 1 or Zollinger-Ellison syndrome

Evaluation and Nonprocedural Services (Within 1 Year of Initial Evaluation)

- Code 99201−99205 (new patient, office)
- Code 99211−99215 (existing patient, office)
- Code 99241−99245 (consultation, office, non-Medicare)

Procedural Services

Services included in the initial evaluation of the patient with GERD include upper gastrointestinal endoscopy with/without biopsy and ambulatory pH monitoring when appropriately employed in the evaluation of GERD patients according to the following:

- Indications for upper endoscopy
  - Nonresponse to a four- to eight-week empiric trial of twice-daily proton pump inhibitors
  - Troublesome dysphagia
  - Patient at high risk for Barrett’s esophagus (BE) [multiple risk factors]
  - Older than 50 years of age
  - Male sex
  - Caucasian, non-Hispanic ethnic origin
  - Hiatal hernia
  - Elevated body mass index
  - Intra-abdominal fat distribution

- Follow-up to a previous upper endoscopy revealing severe esophagitis (Los Angeles class C-D) after two or more months of proton pump inhibitor therapy to exclude BE

Exclusions for the GERD episode include therapeutic upper gastrointestinal endoscopy employed for the diagnosis and treatment of:

- Acute dysphagia/suspected foreign-body ingestion
- Hematemesis, hematochezia, melena
- Imaging concerning for esophageal injury or neoplasia
- Endoscopic mucosal resection/submucosal dissection of mucosal lesions

ESOPHAGEAL MANOMETRY

- Esophageal manometry can be performed after upper endoscopy when there is troublesome dysphagia with no obvious injury from GERD or other findings precluding the need for pH monitoring. These findings include:
  - Reflux stricture.
  - Reflux esophagitis.
  - BE.
  - Esophageal carcinoma.

- Professional fee for ambulatory pH monitoring
  - 91034 Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement
  - 91035 Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement
  - 91037 Esophageal impedance
  - 91038 Esophageal impedance, prolonged (>1 and <24 hours)

- Facility fee

AMBULATORY PH MONITORING AND ESOPHAGEAL REFLUX TESTS

- Ambulatory pH monitoring can be performed during or after upper endoscopy when there is no obvious evidence of esophageal injury from GERD or other findings precluding the need for pH monitoring. These findings include:
  - Reflux stricture.
  - Reflux esophagitis.
  - BE.
  - Esophageal carcinoma.

- Professional fee for ambulatory pH monitoring
  - 91034 Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement
  - 91035 Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement
  - 91037 Esophageal impedance
  - 91038 Esophageal impedance, prolonged (>1 and <24 hours)

- Facility fee

ENDOSCOPIC MANOMETRY

- Endoscopic manometry can be performed after upper endoscopy when there is troublesome dysphagia with no obvious injury from GERD or other findings precluding the need for pH monitoring. These findings include:
  - Reflux stricture.
  - BE.
  - Esophageal carcinoma.
  - Reflux esophagitis.

- Professional fee for esophageal manometry
  - 91010 Esophageal motility
  - 91013 Esophageal motility, with stimulation or perfusion
DYSPLASIA IN BARRETT’S ESOPHAGUS

The AGA episode framework for medical, endoscopic, and surgical evaluation and treatment of dysplasia in BE addresses the following indications:

- To obtain a second opinion, preferably from an expert of endoscopic therapy when esophagitis is found with “indefinite” LGD or HGD, then to repeat endoscopic biopsies to reassess presence of dysplasia.
- As a surveillance strategy for dysplasia with 4-quadrant reversal or progression of dysplasia.
- As endoscopic treatment for confirmed LGD by ablative therapy per available modalities, eg, by thermal or other means.
- As endoscopic treatment for confirmed HGD by ablative therapy per available modalities, eg, by thermal or other means, or resection therapy per available modalities, eg, endoscopic mucosal resection and endoscopic submucosal dissection.

Population Exclusions

- Esophageal carcinoma deemed not amenable to endoscopic therapy
- Patients undergoing surgical resection
- Coagulopathy or bleeding disorder

Procedures

See Appendix A.

1. General exclusions:
   - Evaluations and management (E/M) services provided by patient’s primary care physician/qualified health-care professional
   - Emergency department services provided by physician/qualified health-care professional
   - Surgical services (includes E/M and procedural) to treat a complication of endoscopy
   - Anesthesiologist services to treat a complication of endoscopy that warrants surgical intervention

ANTI-REFLUX SURGICAL AND ENDOSCOPIC INTERVENTIONS

The AGA episode framework for endoscopic and surgical treatment of GERD addresses the following indications:

- As a maintenance therapy for patients with typical GERD symptoms who respond well to medical therapy and have well-documented GERD.
- As a therapeutic service for patients with typical or atypical symptoms who do not respond to medical therapy. In this case, the diagnosis of GERD must be re-evaluated and confirmed with ambulatory pH/impedence testing before anti-reflux surgery.
- As a maintenance therapy for patients with BE who are undergoing endoscopic mucosal ablation.
- As therapy when patients have complications of GERD (such as stricture) or BE.
- As therapy when patients are unable to be compliant with medical therapy (side effects or complications of medical therapy).

Population Exclusions

- Morbidly obese patients; gastric bypass is the preferred operation
- Pediatric, age younger than 18 years
- Esophageal varices
- Patients with history of the following premalignant conditions

Preoperative Services

1. Preprocedure evaluation: determination of suitability for surgical therapy and need for additional testing.
   - a. Code 99201−99205 (new patient, office)
   - b. Code 99211−99215 (existing patient, office)
   - c. Code 99241−99245 (consultation, office, non-Medicare)

2. Preprocedure testing
   - a. Esophageal manometry codes 91010, 91013
   - b. Gastric manometry code 91020
   - c. Esophageal reflux tests codes 91037, 91038, 91034, 91035
   - d. Radiology barium examinations code 74249
   - e. Upper endoscopy codes 43197, 43198, 43200, 43202, 43325, 43329
   - f. Nuclear medicine gastric emptying code 78264

3. Follow-up clinic visit to review diagnostic studies and give informed consent regarding operation
   - a. Code 99211−99215 (existing patient, office)

4. Prophylactic antibiotics, deep vein thrombosis prophylaxis

5. Preprocedure blood tests
   - a. Prothrombin time, partial thromboplastin time, international normalized ratio, complete blood count, chemistry panel

NONDYSPLASTIC BARRETT’S ESOPHAGUS

There is controversy based on the strength and interpretation of evidence regarding the need for screening and appropriate surveillance interval for nondysplastic BE. At present, the published literature does not support performing screening of asymptomatic patients for esophageal cancer at any age. Men or women older than 50 years with chronic GERD symptoms of >5 years duration, nocturnal reflux symptoms, hiatal hernia, elevated body mass index, tobacco use, intra-abdominal distribution of fat, and family history of esophageal cancer are at the highest risk for BE and esophageal adenocarcinoma.

The following framework is suggested as an approach to the management of nondysplastic BE:

1. Upper endoscopy (transnasal esophagoscopy, transoral esophagoscopy, esophagastroduodenoscopy [EGD]) can be performed to detect esophageal adenocarcinoma and/or BE in men or women older than 50 years with chronic GERD symptoms (symptoms for more than five years) and one or more additional risk factors, including:
   - b. Hiatal hernia.
   - c. Elevated body mass index.
   - d. Tobacco use.
   - e. Intra-abdominal distribution of fat.

2. Surveillance evaluation of men and women with a history of BE:
   - a. In men and women with BE and no dysplasia, surveillance examinations could occur at intervals no more frequently than three to five years.
   - b. More frequent surveillance intervals are indicated in patients with BE and dysplasia.
b. Electrocardiography
c. Anesthesia evaluation

**Surgery (Hospital Stay 1–4 Days)**

1. Professional fee for laparoscopic/open antireflux surgery
   a. Code 43280 Laparoscopy, surgical, esophagogastroduodenoscopy (e.g., Nissen, Toupet procedures)
   b. 43327 Esophagogastroduodenoscopy partial or complete, laparotomy
c. 43328 Esophagogastroduodenoscopy partial or complete, thoracotomy
d. 43281 Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh
e. 43282 Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh
f. 43283 Laparoscopy, surgical, esophageal lengthening procedure (e.g., Collis gastroplasty or wedge gastroplasty)
g. 43289 Laparoscopy procedure, esophagus, unlisted
h. 03927 Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (e.g., magnetic band)

2. Professional fee for endoscopic antireflux procedures*
   a. 43210 EGD, transoral, with esophagogastroduodenoscopy
   b. 43257 EGD with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia
   c. Endoscopy to treat BE with endoscopic RF ablation
   d. Anesthesiologist services to treat a complication of surgery
   e. Anatomic pathology services incurred to treat a complication of surgery
   f. All other services not specifically enumerated under professional fee

Postoperative Global Period for Laparoscopic Antireflux Procedures (90 Days)

**Post-Endoscopic Procedure Interval (7 Days)**

1. Post-procedure evaluation/management follow-up
   a. Services performed by endoscopist (includes other physicians and qualified health-care professionals (physician assistant, nurse practitioner) who bill under same taxpayer identification number)
      i. Codes 98212–98215 (E/M office or other outpatient visit)
      ii. Codes 99441–99443 (5–10 minutes of discussion via telephone) (not covered by Medicare)
   b. Emergency department services provided by physician/qualified health-care professional outside of surgeons/endoscopist’s same taxpayer identification number
   c. Surgical services (includes E/M and procedural) to treat a complication of endoscopy and surgery
   d. Anesthesiologist services to treat a complication of surgery that warrants surgical intervention
   e. Anatomic pathology services incurred to treat a complication of surgery
   f. All other services not specifically enumerated under 1–3

3. General inclusions:
   a. Upper endoscopy with biopsies to evaluate esophagus and determine status of esophagus within six months of the elective procedure
   b. Postoperative upper endoscopy with dilation to treat dysphagia
      i. 43220 Esophagoscopy with transendoscopic balloon <30-mm dilation
      ii. 43226 Esophagoscopy with guide wire and dilation
      iii. 43248 EGD with guide wire and dilation
      iv. 43249 EGD with transendoscopic balloon <30-mm dilation
   c. Endoscopy to treat BE with endoscopic RF ablation
      i. 43229 Esophagoscopy with ablation
      ii. 43270 EGD with ablation

**APPENDIX A**

**Preprocedure preparation**
- Prophylactic antibiotics
- Preprocedure blood tests (if required)
  - Prothrombin time, partial thromboplastin time, international normalized ratio, complete blood count, chemistry panel

**Upper endoscopy procedure**
- Professional fee for upper gastrointestinal endoscopy
  - 43197 Transnasal esophagoscopy
  - 43198 Transnasal esophagoscopy, with biopsy
  - 43200 Esophagoscopy
  - 43202 Esophagoscopy, with biopsy
  - 43235 Esophagogastroduodenoscopy
  - 43239 Esophagogastroduodenoscopy, with biopsy
- Facility fee for upper endoscopy
- Sedation fee
  - Monitored anesthesia care services provided by anesthesiologist or nurse anesthetist (anesthesia professional)
    - Code 00740 (5 base units, 1 unit for each 15 minutes of service), including the following:
      - Physical Status Modifiers P3 (some functional limitations; has a controlled disease of more than one body system or one major system; no immediate danger of death; controlled congestive heart failure, stable angina, old heart attack, poorly controlled hypertension, morbid obesity, chronic renal failure, and bronchospastic disease with intermittent symptoms), P4 (has at least one severe disease that is poorly controlled or at end stage; possible risk of death; unstable angina, symptomatic chronic obstructive pulmonary disorder, symptomatic congestive heart failure, hepatorenal failure), or PS (not expected to survive >24 hours without surgery; imminent risk of death; multi-organ failure, sepsis syndrome with hemodynamic instability, hypothermia, poorly controlled coagulopathy)

- 00741 (add-on code for patients older than 70 years)

- 00745 (add-on code for utilization of controlled hypotension)

- 00750, 00756, including:
  - Hemodynamic instability, hypothermia, poorly controlled coagulopathy

- 00760, 00765, including:
  - Morbid obesity, chronic renal failure, and bronchospastic disease with intermittent symptoms
  - Morbid obesity, chronic renal failure, and bronchospastic disease with intermittent symptoms

- 00770, 00775, including:
  - Morbid obesity, chronic renal failure, and bronchospastic disease with intermittent symptoms
  - Morbid obesity, chronic renal failure, and bronchospastic disease with intermittent symptoms

- 00790, including:
  - Morbid obesity, chronic renal failure, and bronchospastic disease with intermittent symptoms
  - Morbid obesity, chronic renal failure, and bronchospastic disease with intermittent symptoms
At the time of this article, moderate sedation provided by the professional performing the endoscopic service (codes 99143–99145) is inherent to most endoscopic procedures and not reimbursed separately.

In 2017, the American Medical Association Current Procedural Terminology® Editorial Panel is anticipated to release a new code set for moderate sedation services. At that time, it is anticipated that CMS will remove the value of moderate sedation from services where it is currently inherent to allow for the separate reporting and payment for moderate sedation when provided, regardless of whether provided by the proceduralist or an anesthesia professional.

Computer-assisted moderate sedation
Pharmaceuticals for sedation
Midazolam, meperidine, fentanyl, propofol, etc.

Biopsy fee for pathology specimens
Cytology
88104 Cytology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation

Anatomic pathology
88304 Level III surgical pathology
88305 Level IV surgical pathology
88306 Level V surgical pathology
Special stains
88312 Group I for micro-organisms
88313 Group II all other (eg, iron, trichromes), except stain for micro-organisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry
88314 Special stain including interpretation and report; histochromal stain on frozen tissue block
88319 Group III, for enzyme constituents
88341 Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure
88342 Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure
88344 Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure
88344 Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure

References available online at http://www.gastrojournal.org/article/S0016-5085(16)00228-6/fulltext.

* This information has been updated from the episode’s initial publication in Gastroenterology in April 2016. Changes will be reflected in a forthcoming issue of Gastroenterology.

Outline of GERD Episode Pathway

**Define population (1)**

**Clinical assessment (2)**

**Procedural intervention (3)**

**Empiric therapy (4)**

**Barrett’s esophagus (3)**

**GERD (3)**

**Not GERD (3)**

**Medical therapy for GERD (6)**

**Surgical therapy for GERD (7)**

**Definitions**

- Inclusion criteria
  - Typical reflux syndrome
  - Reflux chest pain syndrome (previous determination of low-risk for ischemic heart disease)
  - Extra-esophageal syndromes with established association with GERD
    - Cough
    - Asthma
    - Chronic laryngitis/voice disturbance
    - Dental erosion
  - Extra-esophageal syndromes with proposed association with GERD
    - Pharyngitis
    - Sinusitis
    - Idiopathic pulmonary fibrosis
    - Recurrent otitis media

- Exclusion criteria
  - Pediatric patients (younger than 18 years)
  - An established diagnosis of:
    - Esophageal carcinoma
    - Anatomic esophageal anomaly
    - Esophageal dysmotility disorder
    - MEN1 or Zollinger-Ellison syndrome

**Indications for procedural intervention**

- Non-response of symptoms to a 4–8 week empiric trial of twice-daily PPI
- Troublesome dysphagia
- Patient at high risk for Barrett’s esophagus (multiple risk factors)
  - > 50 yo
  - Male sex
  - White race
  - Hiatal hernia
- Elevated BMI
- Intra-abdominal fat distribution
- Follow-up to an initial upper endoscopy revealing severe esophagitis (LA class C-D) after at least two months of therapy to exclude Barrett’s esophagus
- Empiric therapy
  - 4-8 week of twice-daily PPI
  - Reassess for response at end of trial
  - If symptom control is achieved, patients could be tapered to the minimal dosage required to control symptoms

**Clinical care pathways are point-of-care clinical decision support tools to promote high-value, evidence-based patient care. They are formulated by an expert physician panel through the review of existing clinical practice guidelines and systematic reviews. For pathway decision points where no guidelines or systematic reviews exist, recommendations are made based on a review of the available data. The information contained above and in the following four pages is a companion to two articles in the April 2016 issue of Gastroenterology. Vaezi MF, et al. Gastroenterology 2016; 150:1009-1018; Vaezi MF, et al. Gastroenterology 2016; 150: 1019-1025.**
Upper endoscopy indications

- Non-response of symptoms to a 4–8 week empiric trial of twice-daily PPI
- Troublesome dysphagia
- Patient at high risk for Barrett’s esophagus (multiple risk factors)
  - > 50 yo
  - Male sex
  - White race
  - Hiatal hernia
  - Elevated BMI
  - Intra-abdominal fat distribution
Follow-up to an initial upper endoscopy revealing severe esophagitis (LA class C-D) after at least two months of therapy to exclude Barrett’s esophagus

Exclusion criteria

- EGD employed for the treatment of:
  - Acute dysphagia/suspected foreign body ingestion
  - Hematemesis, hematochezia, melena
  - Imaging concerning for esophageal injury or cancer

Biopsy indications

- Troublesome dysphagia without a specific endoscopic finding (random)
- Identification at endoscopy of:
  - Reflux stricture
  - Barrett’s esophagus
  - Esophageal carcinoma
  - Esophagitis in a immunocompromised patient
  - Severe or proximal esophagitis (LA class C-D)

GORD (5) MEDICAL THERAPY (6)

- Diagnosis based on inclusion criteria and one of the following:
  - Response of symptoms to a 4–8 week empiric trial of twice-daily PPI
  - Identification at upper endoscopy of:
    - Reflux stricture
    - Reflux esophagitis
  - Ambulatory pH monitoring results consistent with a diagnosis of GORD

Continuing anti-secretory therapy:

- After symptom control is achieved, patients with GORD can be tapered to the minimal dosage required to control symptoms
- Patients unresponsive to empiric PPI therapy without evidence of GORD by endoscopy or ambulatory pH monitoring could have PPI therapy stopped

Ambulatory pH monitoring indicated during/following upper GI endoscopy when there is no obvious evidence of esophageal injury from GORD or other findings precluding the need for pH monitoring.

Esophageal manometry indicated during/following upper GI endoscopy when there is troublesome dysphagia of unexplained chest pain with no obvious injury from GORD or explanatory anatomic lesion.

Risk factors

- Elevated BMI
- Nocturnal symptoms
- Tobacco use
- Hiatal hernia
- Intra-abdominal fat distribution

Non-dysplastic Barrett’s care pathway:

- Treatment and follow-up (2,3)
  - Non-dysplastic Barrett’s (2)
  - Normal or inflammation (3)

  - Normal or inflammation
    - Treat as per NERD protocol
  - Non-dysplastic Barrett’s
    - Treatment and follow-up (2)
  - Normal or inflammation
    - Treat as per NERD protocol

Non-dysplastic Barrett’s care pathway risk factors:

- Elevated BMI
- Nocturnal symptoms
- Tobacco use
- Hiatal hernia
- Intra-abdominal fat distribution

Non-dysplastic Barrett’s care pathway treatment and follow-up (2,3)

- Non-dysplastic Barrett’s (2)
- Normal or inflammation (3)

  - Medical treatment with PPI minimal dose for symptom relief if present, but at least once daily
  - Repeat endoscopy every 3–5 years with 4 quadrant biopsies every 2 cm


**DYSPLASIA IN BARRETT’S ESOPHAGUS**

- "DYSPLASIA" identified in Barrett’s esophagus
- If endoscopic or histological sign of inflammation
  - Repeat upper endoscopy with biopsies after adequate acid reduction therapy for 6–8 weeks
  - Dysplasia confirmed by another pathologist, preferably from an expert in esophageal histopathology
  - If dysplasia is still present
    - If negative for dysplasia, follow non-dysplastic Barrett’s pathway
    - If dysplasia is still present
      - Low grade dysplasia (LGD)
      - High grade dysplasia (HGD)

**SURVEILLANCE**
- per biopsy protocol* every 12 months
- ABLATIVE THERAPY
  - Radio frequency ablation - RFA**
  - Cryotherapy
  - Photodynamic therapy - PDT
- RESECTIVE THERAPY
  - Endoscopic mucosal resection (EMR)
  - Endoscopic submucosal dissection (ESD)
  - Traditional surgical esophagectomy

**ENDOSCOPIC/SURGICAL TREATMENT OF GERD**

- Indication for evaluation of endoscopic or surgical anti-reflux procedure
- If evidence of endoscopic sign of inflammation on previous endoscopy
  - If there was no endoscopic or historical sign of inflammation on previous endoscopy
    - Esophageal pH to establish pathologic GERD (performed off PPI therapy)
    - If negative for GERD
      - If positive for GERD
        - No contraindication for endoscopic or surgical anti-reflux procedure
  - Esophageal manometry, +/-barium radiographs
- Contra-indication for surgery
- If evidence of endoscopic sign of inflammation on previous endoscopy
  - If positive for GERD
    - If negative for GERD, can evaluate for other potential causes

**SURVEILLANCE**
- per biopsy protocol* every 3–6 months

**ABLATIVE THERAPY**
- Radio frequency ablation - RFA**
- Cryotherapy
- Photodynamic therapy - PDT
**RESECTIVE THERAPY**
- Endoscopic mucosal resection (EMR)
- Endoscopic submucosal dissection (ESD)
- Traditional surgical esophagectomy

**ENDOSCOPIC/SURGICAL TREATMENT OF GERD**

- Contra-indication for surgery
- Small hiatal hernia
- Large hiatal hernia
- Continue medical therapy
- Laparoscopic surgical anti-reflux procedure and hiatal hernia repair
- Consideration of endoscopic procedure or minimally invasive magnetic sphincter augmentation

*Biopsy protocol: using white light endoscopy can take 4 quadrant biopsies every 1 cm plus any nodules or mucosal irregularities, with all specimens at one level placed in one specimen container.

**RFA has success eradicating LGD > 90% of treated cases, and in 70–80% of patients with HGD.**

For HGD in nodules or mucosal irregularities, en bloc resection via EMR/ESD enables staging; ablative therapy can be applied to residual area.
AGA DIGESTIVE HEALTH RECOGNITION PROGRAM™

The AGA Digestive Health Recognition Program™ (DHRP™) is a quality improvement program and clinical data registry that allows clinicians to demonstrate quality of care in colorectal cancer (CRC) screening and surveillance, and management of patients with hepatitis C virus (HCV) and/or IBD. The program allows participants to submit data for the CMS Physician Quality Reporting System (PQRS).

AGA QUALIFIED CLINICAL DATA REGISTRY

Qualified Clinical Data Registries (QCDR) will continue to play a role in quality reporting under the new Merit-based Incentive Payment System (MIPS) beginning in 2017, which will account for at least 50 percent of performance under the new law. MIPS is one path under the new Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) designed to advance a health-care system of high-quality, efficient and coordinated care.

AGA has maintained a CMS-approved QCDR since they were authorized under the Affordable Care Act in 2013. AGA’s 2016 QCDR will not only help you meet the standards established under the new MIPS, but will also meet the final year of requirements for PQRS reporting.

The 2016 AGA QCDR is different than the QCDR offered in previous years. This year, the AGA QCDR allows gastroenterologists and hepatologists to report 19 measures across several clinical topics within a single QCDR, including measures for colorectal cancer CRC screening and surveillance, HCV, and IBD, as well as your choice of several cross-cutting measures.

HOW THE AGA QC DR WORKS

In collaboration with CECity, AGA is working with electronic health record (EHR) vendors, including NextGen, Allscripts and others, to create the capacity for EHRs to electronically transmit data from an EHR to the AGA QC DR.

Through agreements between CECity and EHRs, participants in the AGA DHRP will also be able to use Stage Two requirements for special registry reporting, if you use a participating EHR, which is one of the requirements to avoid payment adjustments under the Affordable Care Act. Meaningful use through certified EHR technology is one of the four components of MIPS reporting starting in 2017. Read more at http://ow.ly/4ns74v.

The DHRP can be used to improve the quality of your practice by allowing you to benchmark your practice nationally with other providers. Many providers utilize other reporting options to meet their PQRS requirements, however other reporting options do not allow a provider to determine the quality of care that they are providing and areas for improvement. Using the DHRP QCDR for Quality Improvement Benchmarking, you will have a total of 19 measures to select and report from a variety of topics important to gastroenterology. You may report on as many measures and patient records as you want and multi-year use will allow you to determine if your practice is improving quality of care over time, and will help you identify gaps in care to improve patient outcomes.

WHAT ARE QCDRS?

QCDRs provide a standard to satisfy Physician Quality Reporting System requirements based on satisfactory participation. They are used to collect medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. The data submitted to CMS via a QCDR covers quality measures across multiple payors and is not limited to Medicare beneficiaries.

Registration for the 2016 AGA QCDR is available at https://www.medconcert.com/content/medconcert/AGAQIR.
AGA QUALIFIED REGISTRY — INFLAMMATORY BOWEL DISEASE (IBD)
AGA maintains IBD process measures and is developing IBD outcomes measures.

<table>
<thead>
<tr>
<th>PQRS Performance Measure</th>
<th>Measure Title</th>
</tr>
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<tbody>
<tr>
<td>110</td>
<td>Influenza Immunization</td>
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<tr>
<td>111</td>
<td>Pneumonia Vaccination Status for Older Adults</td>
</tr>
<tr>
<td>226</td>
<td>Tobacco Screening and Cessation Intervention</td>
</tr>
<tr>
<td>270</td>
<td>Corticosteroid Sparing Therapy</td>
</tr>
<tr>
<td>271</td>
<td>Corticosteroid Related Iatrogenic Injury — Bone Loss Assessment</td>
</tr>
<tr>
<td>274</td>
<td>Testing for Latent Tuberculosis (TB) Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy</td>
</tr>
<tr>
<td>275</td>
<td>Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy</td>
</tr>
</tbody>
</table>

AGA QUALIFIED REGISTRY — HEPATITIS C (HCV)
AGA maintains HCV and other liver disease measures with AASLD and the Infectious Diseases Society of America.

<table>
<thead>
<tr>
<th>PQRS Performance Measure</th>
<th>Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>84</td>
<td>HCV Ribonucleic Acid (RNA) Testing Before Initiating Treatment</td>
</tr>
<tr>
<td>85</td>
<td>HCV Genotype Testing Prior to Treatment</td>
</tr>
<tr>
<td>87</td>
<td>HCV Ribonucleic Acid (RNA) Testing Between 4–12 Weeks After Initiating Treatment</td>
</tr>
<tr>
<td>130</td>
<td>Documentation of Current Medications in the Medical Record</td>
</tr>
<tr>
<td>183</td>
<td>Hepatitis A Vaccination in Patients with HCV</td>
</tr>
<tr>
<td>226</td>
<td>Tobacco Screening and Cessation Intervention</td>
</tr>
<tr>
<td>390</td>
<td>Discussion and Shared Decision Making Surrounding Treatment Options</td>
</tr>
</tbody>
</table>
Get Answers to All Your Coding Questions

Use the AGA Coding & Billing Corner

Maximize Reimbursements, Optimize Revenues, Reduce Denials, Improve Compliance

The AGA Coding & Billing Corner uses AAPC’s certified professional GI coding and billing specialists to handle all your coding needs. AAPC is the nation’s largest training and credentialing organization for the business side of health care. They offer insight on topics such as:

- CPT, HCPCS, and ICD-9 and ICD-10 coding for GI procedures.
- Federal reimbursement policy for GI services.
- Selecting the appropriate category of service for the evaluation and management code.
- Documentation guidelines for evaluation and management service.
- Documentation requirements for teaching physician
- The proper use of the advance beneficiary notice.
- Billing non-covered service.

Just submit your questions online. Questions will be answered within 48 business hours upon receipt and will be sent by email.

AGA members receive two free questions per month; $9.99 for five additional questions per month.

Non-members pay $19.99 for five questions per month.

Go to www.gastro.org/coding-billing-corner.

2016 CLINICAL DECISION SUPPORT TOOLS

These Clinical Decision Support Tools are based on the latest clinical guidelines to help you treat patients using evidence-based standards of care.

Learn more at www.gastro.org/guidelines.

22 Diagnosis and Management of Lynch Syndrome

23 The Role of Upper Gastrointestinal Biopsy to Evaluate Dyspepsia in the Adult Patient in the Absence of Visible Mucosal Lesions

24 Medical Management of Microscopic Colitis
AGA GUIDELINE FOR
Diagnosis and Management of Lynch Syndrome
CLINICAL DECISION SUPPORT TOOL

**Any new colorectal cancer**
- Tumor testing for MSI or IHC

- **Normal**
  - MLH1 promoter methylation or BRAF

- **IHC abnormal**
  - Missing MLH1
  - MLH1 promoter methylation or BRAF

- **MSI high**
  - Predictive model
    - > 5 percent probability
    - ≤ 5 percent probability

- **BRAF negative or MLH1 promoter not hypermethylated**
  - Germline genetic testing
  - Positive for Lynch mutation
    - Colonoscopy every 1-2 years
    - Consider aspirin
    - Germline genetic testing for 1st degree relatives
  - Negative
    - Consider other familial cancer syndromes

**Family history suggestive of Lynch syndrome, but:**
- No personal history of cancer,
- No known family history of Lynch mutation, and
- Tumor tissue from affected relative not available

**Tumor testing for MSI or IHC**
- Normal
- IHC abnormal
- MSI high

- **Normal**
  - Missing MLH1
  - MLH1 promoter methylation or BRAF

- **IHC abnormal**
  - Missing: PMS2 (and MLH1 present), MSH2, or MSH6

- **MSI high**
  - Predictive model
    - > 5 percent probability
    - ≤ 5 percent probability

- **BRAF negative or MLH1 promoter not hypermethylated**
  - Germline genetic testing
  - Positive for Lynch mutation
    - Colonoscopy every 1-2 years
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  - Negative
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**AGA GUIDELINE ON**
The Role of Upper Gastrointestinal Biopsy to Evaluate Dyspepsia in the Adult Patient in the Absence of Visible Mucosal Lesions
CLINICAL DECISION SUPPORT TOOL

**EGD performed in patients with dyspepsia as the only indication**

- Normal esophagus and GE junction
  - No biopsy
- Normal gastric body and antrum
  - HP status known?
    - No
    - Yes
    - Immunocompromised?
      - Yes
      - No

- Normal duodenum
  - No biopsy

- 5-biopsy Sydney system in 1 jar
  - Routine special stain not warranted
  - Routine special stain not warranted

* Biopsy may be appropriate in patients at high risk for celiac disease
** In post-BMT patients
Work-up should include, but not be limited to, evaluation for celiac disease, hyperthyroidism, irritable bowel syndrome.

2. Maintenance dosing can be tapered to lowest effective dose, which may range from 3 mg every other day to 6 mg daily.

3. Potential precipitating medications include, but are not limited to: NSAIDs, aspirin, PPI, SSRI, clozapine and acarbose.

4. Though direct evidence is very limited, case series suggest that azathioprine and anti-TNF agents may be effective in refractory microscopic colitis.

Review at gastro.org/microcolitis.

Symptomatic microscopic colitis

2nd Line Medical Therapy

- Bismuth subsalicylate
- Prednisone (prednisolone)
- Mesalamine

Budesonide 9mg daily

Treat for 8 weeks

Clinical response

- Yes
- No

Work-up for co-existing causes for diarrhea

- Yes
- No

Budesonide ≤ 6mg daily x 6-12 months

No maintenance therapy

Treat co-existing conditions

- Yes
- No

Avoid possible precipitating medications

- Consider alternative therapies including immunosuppressants

1. Work-up should include, but not be limited to, evaluation for celiac disease, hyperthyroidism, irritable bowel syndrome.

2. Maintenance dosing can be tapered to lowest effective dose, which may range from 3 mg every other day to 6 mg daily.

3. Potential precipitating medications include, but are not limited to: NSAIDs, aspirin, PPI, SSRI, clozapine and acarbose.

4. Though direct evidence is very limited, case series suggest that azathioprine and anti-TNF agents may be effective in refractory microscopic colitis.

AGA DIGESTIVE HEALTH RECOGNITION PROGRAM™

The AGA Digestive Health Recognition Program™ (DHRP) enables clinicians to demonstrate superior quality of care in the treatment of specific disease states. The DHRP’s quality measures are included in the CMS Physician Quality Reporting System (PQRS) for 2016.

Participation in DHRP is simple and easy: register, submit data for a sample of 20 patients for the HCV or IBD modules or for 50 percent of patients for the AGA Qualified Clinical Data Registry. PQRS participation can potentially lead to avoidance of future penalties.

AGA MEMBER: $300 PER DISEASE STATE

NONMEMBER: $550 PER DISEASE STATE

Learn more at www.gastro.org/DHRP.
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