CMS Measure ID/CMS QCDR ID: CAP 42

Measure Title: Barrett's Esophagus: Complete Analysis with Appropriate Consultation

Measure Specifications

Measure Description	Percentage of esophageal biopsy reports for with a diagnosis of Barrett's esophagus that include documentation of a consultation* with a second pathologist for confirmation of dysplasia grading *Consultation at the time of diagnosis or addendum to preliminary pathology report
Denominator Statement	All final pathology reports for esophageal biopsy reports with a diagnosis of Barrett's esophagus CPT®[1]: 88305 **AND** ICD10: • K22.70 Barrett's esophagus without dysplasia • K22.710 Barrett's esophagus with low grade dysplasia • K22.711 Barrett's esophagus with high grade dysplasia • K22.719 Barrett's esophagus with dysplasia, unspecified
Denominator Exclusions	1. Specimens that are exclusively anatomic location(s) other than the esophagus
Denominator Exceptions	1. Malignant neoplasms 2. Absence of intestinal metaplasia 3. Insufficient tissue
Numerator Statement	All esophageal biopsy reports with a finding of Barrett's esophagus, for which consultation with a second pathologist was obtained and documented in the pathology report
Numerator Exclusions	None
Measure Information	
NQS Domain	Communication and Care Coordination
Meaningful Measures Area(s)	Transfer of Health Information and Interoperability
Meaningful Measure Rationale	Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dysplasia (ACG, 2016; AGA, 2011). There is a rapidly rising incidence of adenocarcinoma of the esophagus in the United States. A diagnosis of Barrett's esophagus increases a patient's risk for esophageal adenocarcinoma by 30 to 125 times that of people without Barrett's esophagus (although this risk is still small 0.4% to 0.5% per

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	year)(Conteduca et al 2012, Intl J Onc). Esophageal adenocarcinoma is often not curable, partly because the disease is frequently discovered at a late stage and because treatments are not effective. A diagnosis of Barrett's esophagus could allow for appropriate screening of at risk patients as recommended by the American College of Gastroenterology. Standard endoscopy with biopsy currently is the most reliable means of establishing a diagnosis of Barrett's esophagus. The definitive diagnosis of Barrett's esophagus requires a pathologist's review of an esophageal biopsy. Dysplasia is the first step in the neoplastic process, and information about dysplasia is crucial for clinical decision-making directing therapy. The presence and grade of dysplasia cannot be determined by routine endoscopy, and pathologist's review of a biopsy is essential for recognition of dysplasia, especially given that there are no recommended biomarkers for Barrett's esophagus. Endoscopic surveillance detects curable neoplasia in patients with Barrett's esophagus.
Measure Type	Process
Data Source	Laboratory Information Systems; pathology reports
Summary of Performance Gap Evidence	In 2024, 15 reporting entities submitted data to CMS for all 12 months of the year. The average performance rate was 94.6. The minimum performance rate was 71.43% and the maximum was 100%. Through 1 July 2025, 13 practices have begun submitting data to the registry. The average performance rate is 92.7% with scores as low as 6.12% and as high as 100%. 1. "Although confirmed LGD is a strong predictor of progression to high-grade dysplasia (HGD)/EAC, adherence to the recommended expert review is poor and both generalist pathologists and expert pathologists are prone to significant interobserver variability, making the clinical management of LGD very challenging" Khoshiwal AM et al (2023) The Tissue Systems Pathology Test Outperforms Pathology Review in Risk Stratifying Patients with Low-Grade Dysplasia. Gastroenterology. 165(5):1168-1179 E6. 2. "…interpretation of mucosal biopsies by pathologists suffers from a significant degree of interobserver variability, which has not shown significant improvement over the past several decades" Patil, DT et al (2024). WATS3D: An Interobserver Study of Barrett's Esophagus–Associated Dysplasia Among Gastrointestinal Pathologists. Clinical and Translational Gastroenterology 15(2):p e00661. 3. "There is substantial disagreement among pathologists for interpreting dysplastic BE [Barrett's Esophagus], particularly for LGD [low-grade dysplasia]. Community pathologists tend to be overly sensitive in their interpretation at the detriment of specificity for risk of progression, and expert pathologists may tend to be more specific, but at the detriment to sensitivity." Rubenstein JH et al (2024) AGA Clinical Practice Guideline on Endoscopic Eradication Therapy of Barrett's Esophagus and Related Neoplasia. Gastroenterology 166(6):1020-1055

Measure Owner	College of American Pathologists
NQF ID	N/A
Number of Performance Rates	1
Overall Performance Rate	1st Performance Rate
High-priority	Yes
Improvement Notation	Inverse Measure: No **Proportional Measure: Yes (Higher score indicates better quality)** Continuous Variable Measure: No Ratio Measure: No Risk-adjusted: No
Care Setting and Specialty	Care Setting: Other—Laboratories; Telehealth not applicable Specialty: Pathology
Submission Pathway	Traditional MIPS
Current Clinical Guideline the Measure is Derived From	Shaheen NJ et al (2022). Diagnosis and Management of Barrett's Esophagus: An Updated ACG Guideline. *Am Jour Gastr* 117(4):559-587. "We recommend that dysplasia of any grade detected on biopsies of BE be confirmed by a second pathologist with expertise in gastrointestinal (GI) pathology"