Colorectal Cancer Screening (COL)

Q: Which members are included in the sample?

A: Members 50-75 years of age who had one or more appropriate screenings for colorectal cancer.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a note indicating the **date** the colorectal cancer screening was performed. Appropriate screenings are defined by **any** of the following:

- ☑ Fecal Occult Blood Test in **2015**; guaiac (gFOBT) or immunochemical (iFOBT)
- ☑ Flexible sigmoidoscopy performed in **2011**, **2012**, **2013**, **2014** or **2015**
- ☑ Colonoscopy in **2015** *or* ***within 9 years prior to 2015***.

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Health Maintenance Form
- ☑ Progress notes/Office visits notes
- ☑ Problem List
- ☑ Laboratory/Pathology Reports
- ☑ Medical History Forms
- ☑ X-ray Reports
- ☑ GI Consults/ Reports/ Flowcharts
- ☑ Complete Physical Examination Fo

Note: Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

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Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Prior to each visit for members 50 years and older, review chart to determine if COL screening has been completed, if not, discuss options with member, as colonoscopy every 10 years and stool testing done yearly are shown to have similar effectiveness in identifying colon cancer.
- ☑ Request a supply of stool screening test kits from your contracted lab(s) to have on hand to share with members when at office visits.
- ☑ If a member reports having had a colonoscopy, request that the member share a copy of the results/report or provide contact information of the rendering provider so that office staff can call to request the member's colonoscopy results/report. Remember to attach this information to the member's medical record for documentation purposes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ *Exclude members with diagnosis of colorectal cancer or total colectomy (Use designated Value Set for each)*

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SAMPLE CODES

FOBT:
CPT codes 82270, 82274 **HCPCS Code** G0328

Flexible Sigmoidoscopy:
45330-45335, 45337-45342, 45345 **PCS code** G0104

Colonoscopy:
45378 **HCPCS codes** G0105, G0121

Exclusion ICD-10 Code:
C18.9, Z90.49