Colorectal Cancer Screening (COL)

By working together, we can improve health outcomes for your patients, our members. The Healthcare Effectiveness Data and Information Set (HEDIS®) helps us measure many aspects of performance. This tip sheet provides key details of the HEDIS measure for colorectal cancer screening.

What is the measure?

This measure focuses on members between the age of 45 and 75 who had appropriate screening for colorectal cancer. Appropriate screenings are defined by one of the following:

- Colonoscopy – 10 years (during the measurement year or the nine years prior to the measurement year)
- Computerized tomography (CT) colonography or flexible sigmoidoscopy – five years (during the measurement year or the four years prior to the measurement year)
- Stool DNA (sDNA) with fecal immunochemical test (FIT)-DNA (Cologuard®) test – three years (during the measurement year or the two years prior to the measurement year)
- Fecal occult blood test (FOBT) – one year (during the measurement year)

How to Improve Your Score

- Discuss the importance of colorectal cancer screenings and ensure your patients are up to date with their colorectal cancer screening.
- Once you have ordered a colorectal screen test for your patient or referred them for a colonoscopy, please have your staff follow up with the patient to confirm the screening has been completed.
- Clearly document past medical, surgical, and diagnostic procedures in the medical record, include dates and results.
- Submit claims and encounter data in a timely manner.

Acceptable Forms of Documentation

- Documentation in the medical record must include a note indicating the date the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the patient's medical history section of the record. If this is not clear, the result or findings must also be present. This ensures the screening was performed and not just ordered.
- Member-reported colorectal cancer screenings are acceptable if the screening is documented in the patient's medical history (e.g., member reports colonoscopy in 2015 was normal).
- A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date the screening was performed.

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HEDIS Measure: Colorectal Cancer Screening (COL) *(continued)*

Acceptable Forms of Documentation

- A certain number of samples are required for numerator compliance depending on which type of FOBT test is used: guaiac (gFOBT) or immunochemical (FIT). To determine member compliance, follow these steps:
  1. If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned and the member meets the screening criteria for inclusion in the numerator.
  2. If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if three or more samples are specified. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.
  3. FIT tests may require fewer than three samples. If the medical record indicates that FIT was done, the member meets the screening criteria regardless of how many samples were returned.
  4. If the medical record indicates a gFOBT was done, follow these scenarios:
     - If the medical record does not indicate the number of returned samples, assume the required number was returned and the member meets the screening criteria for inclusion in the numerator.
     - If the medical record indicates three or more samples were returned, the member meets the screening criteria for inclusion in the numerator.
     - If the medical record indicates fewer than three samples were returned, the member does not meet the screening criteria.

Unacceptable Forms of Documentation

Documentation of a FOBT test performed in an office setting or performed on a sample collected via digital rectal exam (DRE) does **not** count as evidence of a colorectal cancer screening. This is because this sample is not specific enough to screen for colorectal cancer.

Exclusions

- Colorectal cancer anytime during the member's history through December 31 of the measurement year
- Total colectomy anytime during the member's history through December 31 of the measurement year
- Members age 66 and older as of December 31 of the measurement year with frailty **and** advanced illness (***Note:*** Members must meet **both** frailty and advanced illness criteria to be excluded.)
- Members in hospice care or using hospice services during the measurement year
- Members receiving palliative care during the measurement year
- Members who died anytime during the measurement year

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HEDIS Measure: Colorectal Cancer Screening (COL) *(continued)*

Exclusion Codes

Colorectal Cancer:
ICD-10: C18.0 – C18.9; C19 – C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Total Colectomy:
CPT: 44150 – 44153, 44155 – 44158, 44210 – 44212
ICD-10: 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

Palliative Care:
HCPCS: G9054, M1017

Hospice Care:
HCPCS: G0182, G9473 – G9479, Q5003 – Q5008, Q5010, S9126, T2042 T2046
CPT: 99377 – 99378

Coding

FOBT:
CPT: 82270, 82274
HCPCS: G0328

Flexible Sigmoidoscopy:
CPT: 45330 – 45335, 45337 – 45338, 45340 – 45342, 45346 – 45347, 45349, 45350
HCPCS: G0104

Colonoscopy:
CPT: 44388 – 44394, 44397, 44401 – 44408, 45355, 45378 – 45393, 45398
HCPCS: G0105, G0121

CT Colonography:
CPT: 74261 – 74263

SDNA FIT-DNA – Cologuard®
CPT: 81528