Colorectal Cancer Screening (COL-E)

Colorectal Cancer Screening (COL-E) Measure year 25 | Weight = 1

Measurement period
January–December

Eligible population
Patients 45–75 years of age must have appropriate screening for colorectal cancer

Note: Colorectal Cancer Screening (COL-E) is reported via Electronic Clinical Data Systems (ECDS), which is a method of reporting clinical data electronically.

Providers do not need to change their documentation or claim/encounter processes.

Service needed for measure compliance
All eligible patients must have a colorectal cancer screening that encompasses the measure year.

- Fecal occult blood test (FOBT), guaiac FOBT or immunochemical FOBT (FIT) is compliant for the year it is performed
- Stool DNA (sDNA) with FIT test is compliant for the year it is performed and two years after
- Flexible sigmoidoscopy or computed tomography (CT) colonography is compliant for the year it is performed and four years after
- Colonoscopy is compliant for the year it is performed and nine years after

Note: Clear documentation of previous colonoscopy, CT colonography or sigmoidoscopy, including year performed, is required.

These services do not close the gap: Digital rectal exams (DRE), FOBT performed in an office setting, FOBT performed on a sample collected via DRE.

Exclusions

- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who have had a total colectomy or colorectal cancer anytime during the patient's history through Dec. 31 of the current measurement year
- Patients who were dispensed dementia medications
- Patients who died anytime during the measurement year
- Patients 66 years of age and older as of Dec. 31 of the measurement year who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older who have frailty and advanced illness

Note: Partial colectomy is not an exclusion.

Measure best practices

- Obtain and review new patients' past 10 years of medical records to determine any colon cancer screenings they may have had in that time period.
- Have a process for appropriate follow-up and documentation of a test when ordering/referring patients for colon cancer screenings.
- Document date of service (at minimum month and year) of the most recent colon cancer screening in the medical record.
- Submit supplemental data to communicate historical evidence of testing and colon cancer screenings completed.
- When patients are not willing/able to complete a colon cancer screening, review Humana reporting to determine if the patient received a test kit. Not all patients are eligible, but if they have received one and not yet completed and returned, the provider should encourage that completion.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Code	Code type	Definition
82270, 82274	Current Procedural Terminology (CPT®)	**Pathology/laboratory codes:** Fecal occult blood test between Jan. 1 and Dec. 31 of the current year
G0328	Healthcare Common Procedure Coding System (HCPCS)	**Pathology/laboratory codes:** Fecal occult blood test between Jan. 1 and Dec. 31 of the current year
81528	CPT	Cologuard (FIT-DNA) test between Jan. 1 two years prior and Dec. 31 of the current year
45330–45335, 45337, 45338, 45340–45342, 45346, 45347, 45349, 45350	HCPCS	**Surgery/hospital codes:** Flexible sigmoidoscopy between Jan. 1 four years prior and Dec. 31 of the current year
G0104	CPT	**Surgery/hospital codes:** Flexible sigmoidoscopy between Jan. 1 four years prior and Dec. 31 of the current year
74261–74263	CPT	CT colonography between Jan. 1 four years prior and Dec. 31 of the current year
44388, 44391–44394, 44397, 44401–44408, 45355–45393, 45398	CPT	Colonoscopy between Jan. 1 nine years ago and Dec. 31 of the current year
G0105, G0121	HCPCS	Colonoscopy between Jan. 1 nine years ago and Dec. 31 of the current year
708699002	Systemized Nomenclature of Medicine – Clinical Terms (SNOMED)	Colorectal cancer detected by DNA-based stool screening (finding)
841000119107	SNOMED	History of flexible sigmoidoscopy (situation)
851000119109	SNOMED	History of colonoscopy (situation)
119771000119101	SNOMED	History of total colectomy (situation)

The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.

The information offered in this flyer is based on Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications. It is not meant to preclude your clinical judgment.

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