COLORECTAL CANCER SCREENING SPECIFICATIONS 2010

Revised 5-27-2010

MNCM Measure	Colorectal Cancer Screening Direct Data Submission Measure
Description	The Colorectal Cancer Screening Direct Data Submission Measure will capture a clinic site's eligible population who are up to date with appropriate colorectal cancer screening exams.
Methodology	Population identification is accomplished via a query of a practice management system or Electronic Medical Record (EMR) to identify the population of eligible patients (denominator). Data elements are either extracted from an EMR system or abstracted through medical record review. Data is submitted via the direct data submission process using MNCM's portal to upload data files. Full population data may be submitted or a sample of patients per clinic site.
Rationale	Cancer of the colon and rectum is one of the most prevalent forms of cancer and one of the top three leading causes of cancer-related deaths for both men and women. The burden of colorectal cancer rests primarily in older adults. Over 75% of all deaths due to colorectal cancer occur in adults over the age of 65. At an aggregated level, about 6% of all Americans will be diagnosed with colorectal cancer at some point in their lives, but specific populations will be effected at different rates with men more likely to acquire than women, rural populations having higher incidence rates than urban, and American Indian populations seeing incidence rates far greater than other race/ethnicity groups. The colorectal cancer screening measure currently reported by Minnesota Community Measurement comes from the NCQA's HEDIS® colorectal cancer screening rate measure. The measure reports the percentage of patients at a medical group who have received colorectal cancer screening within a 12 month period by capturing the entire population ages 50 to 80 with screening tests either within the reporting period or in the medical history as dictated by the test type. Populations not represented by the current rate include patients who have Medicaid insurance and Medicare Fee For Service patients. Unlike many cancers, colorectal cancer develops in a largely predictable progressive pattern where a small tissue growth in the large intestine can turn cancerous over a period of several months to several years. Screening for colorectal cancer to identify and remove these growths is believed to account for the biggest potential reduction in mortality rates. Preventing the incidence and mortality for colorectal cancer has been a key focus of several state and nationwide initiatives including Healthy People 2010, the Minnesota Cancer Alliance, and the American Cancer Society. A direct data submission measure to identify colorectal cancer screening rates would have the following benefits: a) Can capture screening rates at a clinic site level; b) Can more appropriately capture the entire patient population in a clinic's case mix by including Medicare Fee For Service and Medicaid patients; and c) Will potentially allow for a real impact on the burden and mortality of colorectal cancer due to early detection and prevention associated with increased screening.
Measurement Period	Measurement period will be a fixed 12 month period. July 1, 2010 – June 30, 2011.
Denominator: **Patients eligible for colorectal cancer screening**	Established patients meet <u>all</u> of the following criteria: a) Age range: Patients aged 50 – 75 as of the start of the measurement period (valid birth date range 07/01/1934 – 06/30/1960). b) **Patients with at least two office visits during the past 24 months (07/01/2009 - 06/30/2011) with at least one office visit during the measurement period (07/01/2010 - 06/30/2011)**. c) Provider specialties included: Family Medicine, Internal Medicine, Geriatric Medicine, Obstetrics/Gynecology. d) Eligible provider included: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP).
Exclusions	• Patient was in hospice at any time during the measurement period. • Patient died prior to the end of the measurement period.

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	• Exclude patients with all of the diagnoses below: o Total colectomy (ICD-9 procedure code 45.8 and/or CPT codes 44150, 44151, 44155, 44156, 44157, 44158, 44210, 44211, 44212, 45121) o Colorectal cancer (ICD-9 diagnosis codes 153, 154.0, 154.1, 197.5, V10.05 and/or HCPCS codes G0213, G0214, G0215) • Patient had a CT colonography screening examination performed within the 12-month measurement period or four years prior to the measurement period (07/01/2006-06/30/2011).
Numerator: **Appropriate Colorectal Cancer Screening Exams** Please refer to each data element definition for further instruction on collection**.**	Percentage of all patients aged 50-75 at the start of the measurement period who (during dates of service 07/01/2010 – 06/30/2011) were up to date with appropriate colorectal cancer screening exams. Appropriate exams include colonoscopy, sigmoidoscopy, or fecal blood tests as outlined below: A) **COLONOSCOPY** within the measurement period or prior nine years (Valid dates = 07/01/2001 – 06/30/2011) • Using claims codes: Provide the service date associated with the codes for a colonoscopy. o Accepted colonoscopy CPT codes: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392 o Accepted colonoscopy ICD-9 procedure codes: 45.22, 45.23, 45.25, 45.42, 45.43 o Accepted colonoscopy HCPCS codes: G0105, G0121 ---OR--- • Using an electronic medical record: Provide the date field associated with the date of the colonoscopy procedure. *Note: Date of referral-only not accepted, providers must be able to produce documentation that the colonoscopy was completed (e.g. consult letter, procedure note, or patient self-report).* B) **SIGMOIDOSCOPY** within the measurement period or prior four years (Valid dates = 07/01/2006 – 06/30/2011). • Using claims codes: Provide the service date and code associated with the sigmoidoscopy procedure. o Accepted sigmoidoscopy CPT codes: 45330-45335, 45337-45342, 45345 o Accepted sigmoidoscopy ICD-9 procedure codes: 45.24 o Accepted sigmoidoscopy HCPCS codes: G0104 ---OR--- • Using an electronic medical record: Provide the date field associated with the date of the sigmoidoscopy procedure. *Note: Date of referral-only not accepted, providers must be able to produce documentation that the colonoscopy was completed (e.g. consult letter, procedure note, or patient self-report).*

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	C) **STOOL BLOOD TESTS** • Acceptable stool tests: guaiac FOBT (gFOBT) and fecal immunochemical test (FIT). • Must be done within the measurement year (valid dates = 07/01/2010 – 06/30/2011). • Using claims codes: Provide service date and code associated with the stool test. o Accepted CPT codes: 82270, 82274 o Accepted ICD-9 procedure codes: V76.51 o Accepted HCPCS codes: G0328, G0394 o Accepted LOINC codes: 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3 ---OR--- • Using an electronic medical record: Provide the name of the test used and date field associated with the date of the order of the stool test.

MN Community Measurement Colorectal Cancer Data Collection Form

Dates of Service: July 1, 2010 – June 30, 2011

Data Elements: Complete one form for patients aged 50-75 who meet the visit criteria of two visits in the past two years with one visit during the measurement period of 07/01/2010-06/30/2011.	
Patient's age on date of visit: _____	**Patient identifier:** _____
Provider ID: _____	**Clinic site:** _____
Is the patient up-to-date with colorectal cancer screening?* ❑ YES ❑ NO	**Which screening test did the patient receive and when?*** ❑ Colonoscopy (Date of exam: ____/____/_____) ❑ Sigmoidoscopy (Date of exam: ____/____/_____) ❑ Stool Test – *select one below* (Date of order: ____/____/____) __ FOBT __ FIT

*Note about screening tests and timeframes: Appropriate time frames for screening exams to be considered up-to-date:

- Colonoscopy: To be considered up-to-date with a colonoscopy exam, the procedure must have been conducted within the measurement period or up to nine years prior.

  Valid dates = 07/01/2001-06/30/2011

- Sigmoidoscopy: To be considered up-to-date with a sigmoidoscopy, the procedure must have been conducted within the measurement period or up to four years prior.

  Valid dates = 07/01/2006 – 06/30/2011

- Stool test: To be considered up-to-date with a stool blood test, the test needs to be performed within the measurement period. Accepted tests are guaiac fecal occult blood test (gFOBT) and fecal immunochemical test (FIT).

  Valid dates = 07/01/2010 – 06/30/2010