2022 Quality Measure Highlight
Colorectal Cancer Screening

MEASURE DESCRIPTION

The percentage of members 50- 75 years of age who had appropriate screening for colorectal cancer.

Denominator: Members 51 - 75 years of by December 31 of the measurement year.

Numerator: Members ages 51 - 75 years of age who had one or more screenings for colorectal cancer. Any of the following meet the criteria:

- Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four (4) years prior.
- Colonoscopy during the measurement year or the nine (9) years prior.
- CT colonography during the measurement year or the four (4) years prior.
- FIT-DNA test during the measurement year or the two (2) years prior.

Measure Type: Hybrid (medical record/ claims/ lab data)

Coding

ICD9 PCS Colonoscopy: 45.22, 45.23, 45.25, 45.42, 45.43
CPT Colonoscopy: 44388-44394, 44397; 44401-08, 45355; 45378-45393; 45398
LOINC CT Colonography: 60515-4, 72531-7, 79101-2, 82688-3
CPT FIT-DNA: 81528
HCPCS FIT-DNA: G0464
CPT Flexible Sigmoidoscopy: 45330-45335; 45337-45342; 45345-45347; 45349-45350
CPT FOBT: 82270; 82274
LOINC FOBT: 12503-9; 12504-7; 14563-1; 14564-9; 14565-6; 2335-8; 27396-1; 27401-9; 27925-7; 27926-5; 29771-3; 56490-6; 56491-4; 57905-2; 58453-2; 80372-6

*Please refer to Diagnosis Crosswalk in eReports for complete listing of Code Types

Intent / Importance: Treatment for colorectal cancer in its earliest stage can lead to a 64% survival rate five (5) years following diagnosis and 58% at ten years. However, screening rates for colorectal cancer lag behind other cancer screening rates – only about half of people age 50 or older, for whom screening is recommended, have been screened. Colorectal cancer screening in asymptomatic adults between the ages of 51 and 75 can catch polyps before they become cancerous and guide their removal or detect colorectal cancer in its early stages, when treatment is most effective.[1,2]

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[1] American Cancer Society. 2020. “Colorectal Cancer Facts & Figures 2020 2020.” http://www.cancer.org/acs/groups/content/documents/document/acspc-042280.pdf
[2] American Cancer Society. 2020. “Colorectal Cancer Early Detection, Diagnosis, and Staging.” http://www.cancer.org/acs/groups/cid/documents/webcontent/003170-pdf.pdf

PCP QIP 2022	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Medicine Internal Medicine	6 Points 12.5 points	TBD	50th*
Partial Points	Family Medicine Internal Medicine	5 Points 9 Points	TBD	25%

Relative Improvement

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for RI points on the measure **AND**
- Have an RI score of 10% or higher, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.

Please Note

- *Colorectal Cancer Screening in the PCP QIP does not have an NCQA threshold equivalent for PHC. The threshold is the 50th percentile across the entire plan based on the PCP QIP participants' performance in 2019 measurement year.
- For more information, please refer to the PCP QIP Specifications, or contact the QIP Team at QIP@partnershiphp.org.

Compliant Documentation

- Documentation indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the member's "medical history"; if this is not clear, the result or finding must also be present.
- A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed.
- For pathology reports that do not indicate the type of screening and for incomplete procedures:
    - Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.
    - Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

- For FOBT tests:
- If the type of test is not indicated and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
- If the type of test is not indicated and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.
- FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.
- If the medical record indicates that a FOBT was done, follow the scenarios below:
    - *If the medical record does not indicate the number of returned samples,* assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
    - *If the medical record indicates that three or more samples were returned,* the member meets the screening criteria for inclusion in the numerator.
    - *If the medical record indicates that fewer than three samples were returned,* the member does not meet the screening criteria.

Non-Compliant Documentation

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

Exclusions

- Patients who at any time during their history through December 31, 2022 had the following:
    - Colorectal Cancer
    - Total colectomy
    - Members in hospice or receiving Palliative Care during the measurement year.
    - Members 66 years of age and older with frailty **and** advanced illness

Best and Promising Practices

Data and Coding

- Submit claims and encounter data within 90 days of service.
- Exclude members as appropriate and use coding to document reason for exclusion.

Member Care

- Establish a practice commitment to cancer screening.

- Ensure information is consistent, member preference, plain and person-centered, language and culturally appropriate, and delivered in traditional and electronic applications (based on patient's preference).
- Establish a standard practice to assess preventive services. Conduct chart scrubbing prior to the visit to determine if colorectal cancer screening is due.
- Utilize alerts in the EMR/EHR system that each staff member can use to identify and communicate to patients who are due for their colorectal cancer screening at every member encounter.
- Explore possible barriers that may impact screening services, such as access to care, cultural diversity, or anxiety. Offer choices of provider gender and spoken language. Consider cultural beliefs and appropriate language about cancer screening when discussing preventative cancer screening services.
- Train clinical teams on motivational interviewing to have productive conversations about preventative cancer screening.
- Identify and outreach to remind patients to complete FIT kit through phone call or text reminders in two-week and one-week intervals.
- Use approved tailored, targeted education that is an on-going process for patients due for the screening.
- Conduct outreach efforts that rely on several communication/touch points. Combined with physician recommendations, these can have a significant cumulative effect.
- Hand FIT kit out at end of visit, coupled with brief health coaching.
- Mail FIT kit to patients who are due and do not need to be seen for another reason.
- Consider using an equity approach to increase screening rates for targeted communities. By looking at colorectal cancer screening rates by such factors as race, ethnicity, location (ie: zip code), and preferred language, it is possible to identify barriers that affect specific communities, and plan interventions to address these barriers.