



COLORECTAL CANCER SCREENING DATA SPECIFICATIONS

Draft for Reporting Advisory Committee 12/09/09

The Colorectal Cancer Direct Data measure was developed by the colorectal technical advisory committee. In addition to being reviewed by workgroup members, this draft has been shared with the Colorectal Roundtable (a group of community experts working to reduce colon and rectal cancer in Minnesota) and the Wisconsin Collaborative for Healthcare Quality.

MNCM Measure	Colorectal Cancer Screening Direct Data Submission Measure	Comments / Changes
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	<p>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.</p> <p>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 this rate include patients who have Medicaid insurance and Medicare Fee For Service patients.</p> <p>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</p>	

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	<p>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.</p> <p>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.</p>	
Measurement Period	Measurement period will be a fixed 12 month period. July 1, 2010 – June 30, 2011 used as example.	
Denominator: Patients eligible for colorectal cancer screening	<p>Established patients meet <u>all</u> of the following criteria:</p> <ul style="list-style-type: none"> a) Age range: Patients aged 50 – 75 as of the end of the measurement period (valid birth date range 07/01/1935 – 06/30/1960). b) Patients with at least two office visits during the measurement year and year prior (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. 	<p>Age range consistent with USPSTF recommendations and HEDIS® measure.</p> <p>Reviewed by Wisconsin Collaborative for Health Care Quality – suggested changing the wording of the age range to be more specific and consistent with the HEDIS® definition.</p> <p>Have changed the attribution used in other methods by MNCM to match national denominator standards.</p> <p>Included geriatrics and OB/GYN specialties as they are currently required to report this measure for at least one health plan.</p>
Exclusions	<ul style="list-style-type: none"> • Patient was in hospice at any time during the measurement period. • Patient died prior to the end of the measurement period. • Exclude patients with all of the diagnoses below: <ul style="list-style-type: none"> ○ Total colectomy (ICD-9 procedure code 45.8 and/or CPT codes 44150, 44151, 44155, 44156, 44157, 44158, 44210, 44211, 44212, 45121) ○ Colorectal cancer (ICD-9 diagnosis codes 153, 154.0, 154.1, 197.5, V10.05 and/or HCPCS codes G0213, G0214, G0215) 	

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<p>Numerator: Appropriate Colorectal Cancer Screening Exams Please refer to each data element definition for further instruction on collection.</p>	<p>Percentage of all patients aged 50-75 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 occult blood tests as outlined below:</p> <p>A) COLONOSCOPY within the measurement period or prior nine years (Valid dates = 01/01/2001 – 12/31/2010)</p> <ul style="list-style-type: none"> • Using claims codes: Provide the service date associated with the codes for a colonoscopy. <ul style="list-style-type: none"> ○ Accepted colonoscopy CPT codes: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392 ○ Accepted colonoscopy ICD-9 procedure codes: 45.22, 45.23, 45.25, 45.42, 45.43 ○ Accepted colonoscopy HCPCS codes: G0105, G0121 <p>---OR---</p> <ul style="list-style-type: none"> • Using an electronic medical record: Provide the date field associated with the date of the colonoscopy procedure. <p><i>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).</i></p> <p>B) SIGMOIDOSCOPY within the measurement period or prior four years (Valid dates = 01/01/2006 – 12/31/2010).</p> <ul style="list-style-type: none"> • Using claims codes: Provide the service date and code associated with the sigmoidoscopy procedure. <ul style="list-style-type: none"> ○ Accepted sigmoidoscopy CPT codes: 45330-45335, 45337-45342, 45345 ○ Accepted sigmoidoscopy ICD-9 procedure codes: 45.24 ○ Accepted sigmoidoscopy HCPCS codes: G0104 <p>---OR---</p> <ul style="list-style-type: none"> • Using an electronic medical record: Provide the date field associated with the date of the sigmoidoscopy procedure. <p><i>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).</i></p>	<p>For colonoscopy and sigmoidoscopy, staff recommends that patient reported/provider recorded dates of colonoscopies be acceptable.</p> <p>CT Colonography is not included in this recommendation. Although included as an appropriate colorectal cancer screening methodology in the American Cancer Society / US Preventative Services Task Force recommendations, there is limited evidence about the appropriate interval and potential harms associated with exposure to radiation.</p> <p>Double Contrast Barium Enema is not included in this document as an acceptable colorectal cancer screening exam. The use of DCBE has been removed from the HEDIS® specifications. However, it was included in the 2008 USPSTF / American Cancer Society recommendations.</p> <p>Fecal DNA testing (stool DNA or sDNA) is included under the stool testing component. While this test is not included in the HEDIS measure, the 2008 USPSTF / American Cancer Society recommendations include sDNA although the most beneficial interval is unknown.</p> <p>The workgroup recommends that digital rectal exams not be considered as appropriate screening for colorectal cancer.</p>

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	<p data-bbox="380 205 922 233">C) STOOL BLOOD TESTS AND STOOL DNA TESTS</p> <ul style="list-style-type: none"> <li data-bbox="428 254 1016 352">• Acceptable stool tests: guaiac FOBT (gFOBT), fecal immunochemical test (FIT), and stool DNA test (sDNA). <li data-bbox="428 373 1016 436">• Must be done within the measurement year (valid dates = 01/01/2010 – 12/31/2010). <li data-bbox="428 457 1016 772">• Using claims codes: Provide service date and code associated with the stool test. <ul style="list-style-type: none"> <li data-bbox="503 541 902 569">○ Accepted CPT codes: 82270, 82274 <li data-bbox="503 583 967 611">○ Accepted ICD-9 procedure codes: V76.51 <li data-bbox="503 625 935 653">○ Accepted HCPCS codes: G0328, G0394 <li data-bbox="503 667 1008 772">○ Accepted LOINC codes: 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3 <p data-bbox="428 789 513 816">---OR---</p> <ul style="list-style-type: none"> <li data-bbox="428 835 987 934">• 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?* <input type="checkbox"/> YES <input type="checkbox"/> NO	Which test did they receive and when?* <input type="checkbox"/> Colonoscopy (Date of exam: ___/___/____) <input type="checkbox"/> Sigmoidoscopy (Date of exam: ___/___/____) <input type="checkbox"/> Stool Test – <i>select one below</i> (Date of order: ___/___/____) ___ FOBT ___ FIT ___ sDNA

*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 or stool DNA test the test needs to be performed within the measurement period. Accepted tests are guaiac FOBT (gFOBT), fecal immunochemical test (FIT), and stool DNA test (sDNA).

Valid dates = 07/01/2010 – 06/30/2010