HEDIS MEASURE OVERVIEW

Colorectal Cancer Screening (COL-E)

Note: Colorectal Cancer Screening (COL-E) is reported by Humana and other payers 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.

Please note that 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.

Who is included in the COL measure?

The eligible population for this measure includes patients 45–75 years of age who had an appropriate screening for colon cancer between Jan. 1 nine years prior to the measurement year and Dec. 31 of the measurement year, depending on the type of screening (see details below).

Actions to address the COL measure

Healthcare professionals should review the patient's medical record and document one or more screenings for colorectal cancer. Any of the following screenings meet the criteria:

- Colonoscopy during the measurement year or the nine years prior (10 years)
- Flexible sigmoidoscopy during the measurement year or the four years prior (five years)
- Computed tomographic (CT) colonography during the measurement year or four years prior (five years)
- Cologuard (FIT-DNA) test during the measurement year or two years prior (three years)
- Fecal occult blood test (FOBT) during the measurement year (one year)

The date of service needs to be noted along with the results of an FOBT. Digital rectal exams (DRE), FOBT tests performed in an office setting or FOBTs performed on a sample collected via DRE do not satisfy the measure.

Colonoscopies and flexible sigmoidoscopies reported by patients and subsequently recorded in the medical record satisfy the measure. Patient-reported FOBTs are acceptable as long as there is a result and test date. To be compliant, healthcare professionals need to submit proof-of-service documents to Humana with the criteria listed above.

Exclusions

Unless otherwise indicated, these apply to Medicare, Medicaid and commercial patients.

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

Measure best practices

- Clearly document administered screenings, total colectomy or colorectal cancer in the patient's medical record, including the date of service.
- Ask patients if they have had a colorectal cancer screening, and update patient history annually.
- Encourage patients resistant to having a colonoscopy to do an FOBT.

Coding for colorectal cancer screenings

Pathology/laboratory codes: Fecal occult blood test between Jan. 1 and Dec. 31 of the current year	*CPT: 82270, 82274 **HCPCS: G0328
Cologuard (FIT-DNA) test between Jan. 1 two years prior and Dec. 31 of the current year	CPT: 81528
Surgery/hospital codes: Flexible sigmoidoscopy between Jan. 1 four years prior and Dec. 31 of the current year	CPT: 45330–45335, 45337, 45338, 45340–45342, 45346, 45347, 45349, 45350 HCPCS: G0104
CT colonography between Jan. 1 four years prior and Dec. 31 of the current year	CPT: 74261–74263
Colonoscopy between Jan. 1 nine years ago and Dec. 31 of the current year	CPT: 44388, 44391–44394, 44397, 44401–44408, 45355–45393, 45398 HCPCS: G0105, G0121
Please note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association and, if received on claims/encounters submission, will be denied for payment processing.	CPT: 44393, 44397, 45339, 45345, 45355, 45383, 45387 ***ICD-10 Procedure Code: 45.22, 45.23, 45.24, 45.25, 45.42, 45.43

* Current Procedural Terminology (CPT®)

** Healthcare Common Procedure Coding System (HCPCS)

*** International Classification of Diseases, 10th Revision

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.

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