Colorectal Cancer Screening

Measure Basic Information

Name and date of specifications used:
HEDIS® 2018 Technical Specifications for Health Plans (Volume 2).

URL of Specifications: N/A

Measure Type:
HEDIS ■ PQI☐ Survey☐ Other☐ Specify:

Measure Utility:
CCO Incentive■ State Quality Measure■ CMS Adult Core Set☐ CMS Child Core Set■
Other☐ Specify:

Data Source: MMIS/DSSURS, medical records

Measurement Period: January 1, 2018 – December 31, 2018

2013 Benchmark: N/A improvement target only
2014 Benchmark: 47%, Metrics & Scoring Committee consensus.
2015 Benchmark: 47%, Metrics & Scoring Committee consensus.
2016 Benchmark: 47%, Metrics & Scoring Committee consensus.
2017 Benchmark: 50.8%, 2015 CCO 90th percentile.
2018 Benchmark: 54.0%, 2016 CCO 90th percentile.

2018 Improvement Targets: Minnesota method with 2 percentage point floor.

Incentive Measure changes in specifications from 2017 to 2018:
OHA is using HEDIS 2018 specifications for all 2018 measurement. Changes from HEDIS 2017 to 2018 include:

- Add required exclusions to the Medicare product line for members 65 years of age and older living long-term in institutional settings. OHA will exclude Institutional SNP (I-SNP) members when drawing the sample list.
- Revised the Data Elements for Reporting table when using the hybrid method. Note OHA does not report this measure using the HEDIS template, so this change does not apply.
- Added CPT 74261, 74262 to CT Colonography Value Set.

OHA continues to adopt the full HEDIS hybrid specifications for 2018. It is the CCO's responsibility to identify numerator compliance using any of the data sources allowed under the HEDIS hybrid method. Information may be abstracted from administrative data (claims), paper medical records, and audited supplemental databases or from automated systems such as electronic medical records (EMRs), registries, or claims systems.

- If using administrative data to identify numerator compliance, CCOs must follow HEDIS 2018 specifications for allowable codes and measure logic.
- If using medical record data to identify numerator compliance, CCOs must follow HEDIS 2018 specifications to conduct the chart review.

See the guidance document for additional information on allowable data sources. OHA will provide updated guidance to CCOs on the hybrid methodology for 2018 in fall 2018 and samples in early 2019. Guidance will be posted online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx.

HEDIS specifications are written for multiple lines of business and include a broad set of codes that could be used for measurement. Codes OHA is not using include, but are not limited to, LOINC, CPT, and HCPCS codes that are not open to Medicaid in Oregon. A general rule of thumb is that only CPT/HCPCS codes associated with the prioritized list will be used to calculate the measures; however as some measure specifications include denied claims, a claim that was denied because it included codes not on the prioritized list might still be counted toward the measure.

OHA is following HEDIS guidelines for Effectiveness of Care, Access/Availability of Care, Experience of Care, and Utilization measures to determine which services count. OHA is not using all codes listed in the HEDIS specifications.

Member type: CCO A ■ CCO B ■ CCO G ☐

Specify claims used in the calculation:

COL	Claim from matching CCO	Denied claims included
Numerator event	N	Y

Measure Details

Data elements required denominator: Medicaid enrollees age 51-75 years as of December 31st of the measurement year. OHA will provide CCOs with the sampling frame for the chart review.

Required exclusions for denominator:

Exclude Medicare members 65 years of age and older who are, enrolled in an Institutional SNP (I-SNP), or living long-term in an institution any time during the measurement year. OHA will exclude Institutional SNP (I-SNP) members when drawing the sample list.

Exclude members with either of the following conditions any time during the member's history through December 31 of the measurement year[1]:

[1] To note, OHA's claims data only goes back to 2002.

Colorectal Cancer Value Set		
HCPCS	**ICD-9-CM Diagnosis**	**ICD-10-CM Diagnosis**
G0213-G0215, G0231	153, 154.0, 154.1, 197.5, V10.05, V10.06	C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

OR

Total Colectomy Value Set		
CPT	**ICD-9-PCS Procedure**	**ICD-10-PCS Procedure**
44150-44153, 44155-44158, 44210-44212	45.81-45.83	0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

Deviations from cited specifications for denominator: None.

Data elements required numerator: Unique number of individuals receiving at least one of the following screenings for colorectal cancer either during the measurement year or years prior to the measurement year (see table). See **medical record review** section.

Appropriate screenings are defined by:

FOBT Value Set Fecal occult blood test during the measurement year		
CPT	**HCPCS**	**LOINC**
82270, 82274	G0328	2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6

OR

Flexible Sigmoidoscopy Value Set Flexible sigmoidoscopy during the measurement year or four years prior to the measurement year			
CPT	**HCPCS**	**ICD-9-CM Procedure**	**ICD-10-CM Procedure[2]**
45330-45335, 45337-45342, 45345, 45346, 45347, 45349, 45350	G0104	45.24	--

OR

[2] HEDIS 2018 does not include ICD-10 procedure codes for this measure, as ICD-10-PCS is intended for coding procedures performed in inpatient settings, whereas colorectal cancer screenings typically occur in outpatient settings.

Colonoscopy Value Set Colonoscopy during the measurement year or nine years prior to the measurement year			
CPT	**HCPCS**	**ICD-9-CM Procedure**	**ICD-10-CM Procedure[2]**
44388-44394, 44397, 44401-44408, 45355, 45378-45387, 45388-45390, 45391, 45392, 45393, 45398	G0105, G0121	45.22, 45.23, 45.25, 45.42, 45.43	--

OR

CT Colonography Value Set CT colonography during the measurement year or four years prior to the measurement year			
CPT	**HCPCS**	**ICD-9-CM Procedure**	**ICD-10-CM Procedure[2]**
74261, 74262, 74263	--	--	--

OR

FIT-DNA Value Set FIT-DNA during the measurement year or two years prior to the measurement year			
CPT	**HCPCS**	**ICD-9-CM Procedure**	**LOINC**
81528	G0464	--	77353-1, 77354-9

Note: In office FOBT is not a USPSTF recommended procedure.

Required exclusions for numerator: None. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: The measurement year and the year prior to the measurement year.

What are allowable gaps in enrollment: No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.

Define Anchor Date (if applicable): December 31 of the measurement year.

Medical Record Review:

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

A pathology report that indicates the type of screening (e.g. colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria for inclusion in the measure.

For pathology reports that do not indicate the type of screening and for incomplete procedure:

- 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.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

- If the medical record does not indicate the type of test 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 medical record does not indicate the type of test 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 gFOBT 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.

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

For more information: The Colorectal Cancer Screening guidance document and other supporting documents can be found at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx and http://www.oregon.gov/OHA/HPA/CSI-TC/Pages/Resources-Metric.aspx