Colorectal Cancer Screening (COL-E)

APPLICABLE LINES OF BUSINESS

- Commercial
- Medicaid
- Medicare

MEASURE DESCRIPTION

The percentage of members 45-75 years of age who had appropriate screening for colorectal cancer using any of the following tests[i]:

- Colonoscopy during the measurement year or the nine years prior.
- Flexible sigmoidoscopy during the measurement year or the four years prior.
- CT colonography within the measurement year or the four years prior.
- Stool DNA (sDNA) with FIT test (commonly known as Cologuard®) during the measurement year or the two years prior.
- Fecal occult blood test (FOBT) during the measurement year.

EXCLUSIONS

Members are excluded if they:

- Had colorectal cancer (cancer of the small intestine doesn't count).
- Had a total colectomy (partial or hemicolectomies don't count).
- Used hospice services or received palliative care during the measurement year.
- Died any time during the measurement year.
- Are Medicare members 66 years of age and older who are enrolled in an institutional Special Needs Plan (SNP) or living long-term in an institution.
- Are Medicare members 66 years of age or older with advanced illness and frailty (for additional information see the Advanced Illness and Frailty Exclusions Guide).

MEDICAL RECORDS

Patient medical records should include:

- Colorectal cancer screening reports with date of screening and results. Pathology reports taken during a colonoscopy are also acceptable.
- Patient reported screenings are acceptable when the date of screening and type of is documented. A result is not required if the documentation is clearly part of the patient's medical history. If this is not clear, the result or findings must also be present.

CODING

For exclusions, use the appropriate code:

Type	Code	Description
ICD-10[ii]	Z85.038	Personal history of other malignant neoplasm of large intestine
ICD-10	Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
ICD-10	Z51.5	Encounter for palliative care

For screenings, use the appropriate code:

Type	Code	Description
CPT®[iii]	44388-44392, 44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393, 45398	Colonoscopy
HCPCS[iv]	G0105, G0121	
SNOMED[v]	8180007, 12350003, 25732003, 73761001, 174158000, 174185007, 235150006, 275251008, 302052009, 367535003, 443998000, 444783004, 446521004, 446745002, 447021001, 709421007, 710293001, 711307001, 789778002, 1209098000, 48021000087103, 48031000087101, 851000119109	
CPT®	45330-45335, 45337-45338, 45340-45342, 45346, 45347, 45349, 45350	Flexible sigmoidoscopy
HCPCS	G0104	
SNOMED	841000119107	
CPT®	74261, 74262, 74263	Computed tomography (CT) colonography
LOINC[vi]	60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3	
SNOMED	418714002	
CPT®	81528	Stool DNA (sDNA) with FIT test (81528 is specific to the Cologuard® FIT-DNA test)
LOINC	77353-1, 77354-9	
SNOMED	708699002	
CPT®	82270, 82274	Fetal occult blood test (FOBT)
HCPCS	G0328	
LOINC	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	
SNOMED	104435004, 441579003, 442067009, 442516004, 442554004, 442563002, 59614000, 167667006, 389076003, 71711000112103	

NOTE: Performing fecal occult testing on a sample collected from a digital rectal exam (DRE) or on a stool sample collected in an office setting does not meet screening criteria. Date of the procedure must be available when using SNOMED codes to identify history of procedures.

TIPS FOR SUCCESS

Patient Care

- Implement standing orders for screening.
- Educate patients regarding the benefit of early detection through colorectal cancer screening:
    - Colorectal cancer usually starts as growths in the colon or rectum and doesn't typically cause noticeable symptoms.
    - Colorectal cancer can be prevented by removing growths before they turn into cancer.
- Review all the screening options with patients to determine which type of screening they prefer. Patients who are given a choice between colonoscopy and fecal testing, and who review the pros and cons of each with their provider, are more likely to complete the screening.
- Have FIT kits readily available to give patients during the visit with instructions to return them to the office or mail to the lab. Mail patients a home test kit if they are willing to complete an in-home test.
- Be aware of cost barriers and surprise bills to patients when offering colorectal cancer screening:
    - A colonoscopy could be subject to cost-shares if billed using diagnostic codes.
    - Cologuard is processed through a lab that is frequently out-of-network for plans, resulting in high-cost shares for patients.
    - FIT kits are typically considered preventive with no cost shares when processed at an in-network lab.
- Use multi-modal screening reminders, such as mail, phone, or text messages, for patients.
- Use electronic reminders, such as prompts in the EMR, for providers and staff.
- Use telehealth for screening consultations and follow-up of results.

Documentation and Coding

- Partner with your health plan payers to submit electronic data from your EMR.
- Document medical and surgical history in the medical record with dates in structured fields so your EMR can include these in reporting. This will allow the corresponding code to be included in electronic reporting, including claims, to health plans.
- Code for exclusions.
- NCQA has transitioned this measure to an Electronic Clinical Data Systems (ECDS) reported measure. This means that health plans can only use information submitted during the measurement year to qualify for this measure. Information can be submitted electronically (e.g., EMR extracts and FHIR feeds), via claims codes, and in medical record documentation sent to the plan. Plans will no longer perform chart reviews *after* the measurement year for this measure.

---

[i] National Committee for Quality Assurance. HEDIS® Measurement Year 2025 Volume 2 Technical Specifications for Health Plans (2025), 530-536.
[ii] ICD-10-CM created by the National Center for Health Statistics (NCHS), under authorization by the World Health Organization (WHO). WHO-copyright holder.
[iii] CPT Copyright 1983-2019 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
[iv] HCPCS Level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of Centers for Medicare & Medicaid Services, America's Health Insurance Plans, and the Blue Cross Blue Shield Association).
[v] SNOWMED codes are created and maintained by the International Health Terminology Standards Development Organization.
[vi] LOINC codes are created and maintained by Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee.