Measure #113: Colorectal Cancer Screening

DESCRIPTION:
Percentage of patients aged 50 through 80 years who received the appropriate colorectal cancer screening

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

This measure is reported using CPT Category II codes:
CPT E/M service codes and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed CPT E/M service codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who had at least one or more screenings for colorectal cancer during or prior to the reporting period

Numerator Instructions: Patients are considered to have appropriate screening for colorectal cancer if any of the following are documented:

- Fecal occult blood test (FOBT) during the reporting period
- Flexible sigmoidoscopy during the reporting period or the four years prior to the
- reporting period
- Double contrast barium enema (DCBE) or air contrast barium enema during the reporting period or the four years prior to the reporting period
- Colonoscopy during the reporting period or the nine years prior to the reporting period

Numerator Coding:
Colorectal Cancer Screening
CPT II 3017F: Colorectal cancer screening results documented and reviewed

OR

Colorectal Cancer Screening not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 3017F to report documented circumstances that appropriately exclude patients from the denominator

- 1P: Documentation of medical reason(s) for not performing a colorectal cancer screening

OR

Colorectal Cancer Screening not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3017F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified

DENOMINATOR:
All patients aged 50 through 80 years

Denominator Coding:
A CPT E/M service code is required to identify patients for denominator inclusion.
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

RATIONALE:
Colorectal cancer is the second leading cause of cancer-related death in the United States. There were an estimated 135,400 new cases and 56,700 deaths from the disease during 2001. Colorectal cancer (CRC) places significant economic burden on the society as well with treatment costs over $6.5 billion per year and, among malignancies, is second only to breast cancer at $6.6 billion per year (Schrag, 1999).

Colorectal cancer screening can detect pre-malignant polyps and early stage cancers. Unlike other screening tests that only detect disease, colorectal cancer screening can guide removal of pre-malignant polyps, which in theory can prevent development of colon cancer. Four tests are currently available for screening: fecal occult blood testing (FOBT), flexible sigmoidoscopy, colonoscopy, and double contrast barium enema.

CLINICAL RECOMMENDATION STATEMENTS:
During the past decade, compelling evidence has accumulated that systematic screening of the population can reduce mortality from colorectal cancer. Three randomized, controlled trials demonstrated that fecal occult blood testing (FOBT), followed by complete diagnostic evaluation of the colon for a positive test, reduced colorectal cancer mortality (Hardcastle et al., 1996; Mandel & Oken, 1998; Kronborg; 1996). One of these randomized trials (Mandel et al., 1993) compared annual FOBT screening to biennial FOBT screening, and found that annual screening resulted in greater reduction in colorectal cancer mortality. Two case control studies have provided evidence that sigmoidoscopy reduces colorectal cancer mortality (Selby et al., 1992; Newcomb et al., 1992). Approximately 75% of all colorectal cancers arise sporadically (Stephenson et al., 1991). Part of the effectiveness of colorectal cancer screening is mediated by the removal of the precursor lesion—an adenomatous polyp (Vogtelstein et al., 1988). It has been shown that removal of polyps in a population can reduce the incidence of colorectal cancer (Winawer, 1993). Colorectal screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective (Kavanaugh, 1998).

Because of the accumulated evidence, broad consensus has emerged about the virtue of screening individuals aged 50 years or older for colorectal cancer. In 1996, the U.S. Preventive

Services Task Force (USPSTF) published guidelines that recommended screening all persons aged 50 and older for colorectal cancer by annual FOBT or sigmoidoscopy (at unspecified periodicity) or both (USPSTF, 1997). In February 1997, clinical practice recommendations were issued by an interdisciplinary task force originally convened by the Agency for Health Care Policy and Research (AHCPR; the agency has since been renamed the Agency for Healthcare Research and Quality) and supported by a consortium of professional organizations including the American Gastroenterological Association (Winawer, 1997). The American Cancer Society (ACS) has recommended screening for colorectal cancer since 1980 and recently updated its guidelines in January, 2002 (Smith et al., 2002). These updated guidelines recommend colorectal cancer screening starting at age 50 for all persons at average risk of developing colorectal cancer using one of five options for screening: (1) annual FOBT; (2) flexible sigmoidoscopy every 5 years; (3) annual FOBT plus flexible sigmoidoscopy every 5 years; (4) double contrast barium enema (DCBE) every five years; or (5) colonoscopy every 10 years.

The USPSTF released its updated recommendations for colorectal cancer screening in July 2002. The USPSTF strongly recommends that clinicians screen men and women 50 years of age or older for colorectal cancer (A recommendation). The USPSTF found good evidence for FOBT screening, fair evidence for sigmoidoscopy (alone or in combination with FOBT), and no direct evidence for colonoscopy or double contrast barium enema. The USPSTF found insufficient evidence to recommend new technologies, such as virtual colonoscopy. The recommended periodicity is annually for FOBT, every 5 years for sigmoidoscopy and double contrast barium enema, and every 10 years for colonoscopy. FOBT is the only test for which direct evidence on periodicity exists. The intervals for the other tests are based on their sensitivity and the natural course of the disease.