# Colorectal Cancer Screening

*This measure is to be reported for all patients aged 50 through 75 years seen by the clinician — a minimum of **once** per reporting period.*

## Measure description

Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening

## What will you need to report for each patient aged 50 through 75 for this measure?

If you select this measure for reporting, you will report:

- Whether or not the patient had the appropriate colorectal cancer screening performed during or prior to the reporting period

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

- Fecal occult blood test (FOBT) within the last 12 months
- Flexible sigmoidoscopy 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

## What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to screen for colorectal cancer, due to:

- Medical reasons (eg, not indicated, contraindicated, other medical reason)

In these cases, you will need to indicate that the medical reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exclusions).