Surveillance Colonoscopy Interval For Patients with a History of Adenomatous Polyps

*This measure is to be reported **each time** a surveillance colonoscopy is performed for patients aged 18 years and older with a history of colonic polyp(s) in a previous colonoscopy during the reporting period.*

Measure description

Percentage of patients aged 18 years and older receiving a surveillance colonoscopy[1] and a history of colonic polyp(s) in a previous colonoscopy, who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report

What will you need to report for each patient undergoing a surveillance colonoscopy for this measure?

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

- Whether or not you documented a follow-up interval of 3 or more years since the patient's last colonoscopy

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

There may be times when it is not appropriate to have a follow-up interval of 3 or more years between surveillance colonoscopies, due to:

- Medical reasons (eg, patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas)
- System reasons (eg, unable to locate previous colonoscopy report)

In these cases, you will need to indicate which 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).

[1]Clinicians who indicate that the colonoscopy procedure is incomplete or was discontinued should use the procedure number and the addition (as appropriate) of modifier 52, 53, 73, or 74. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will *not* qualify for inclusion into this measure.

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