BlueCross BlueShield of Oklahoma

QUALITY CARE

Colorectal Cancer Screening

We collect quality data from providers to measure and improve the quality of care our members receive. Colorectal Cancer Screening is one aspect of care we measure in our quality programs. Quality measures evaluate a prior calendar year performance.

What We Measure

We capture members ages 45 to 75 who had an appropriate colorectal cancer screening with any of the following tests:

- Fecal occult blood test during the measurement year
- Stool DNA (FIT-DNA or Cologuard®) during the measurement year or two years prior to the measurement year
- Flexible sigmoidoscopy during the measurement year or four years prior
- Computed tomography colonography during the measurement year or four years prior
- Colonoscopy during the measurement year or nine years prior

COL is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure. See the **National Committee for Quality Assurance website** for more details.

Why It Matters

When detected and treated in the earliest stage, colorectal cancer has a **five-year relative survival rate of 90 percent**. Screening asymptomatic adults ages 45 to 75 can catch polyps before they're cancerous and colorectal cancer in the early stages, when treatment is most effective. Learn more from **NCQA**.

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Eligible Population

Members ages 46 to 75 as of Dec. 31 of the measurement year are included in this measure.

Exclusions: Members who meet any of the following criteria are excluded:

- Had colorectal cancer or total colectomy anytime before or during the measurement year
- Were age 66 or older during the measurement year with both frailty and advanced illness
- Received hospice or palliative care during the measurement year
- Had documentation of an FOBT performed in an office setting or on a sample collected via digital rectal exam. This isn't considered an adequate screening test due to low specificity

Tips to Consider

- Discuss the importance of colorectal cancer screenings with members.
- Ensure members are up to date on their screening.
- Clearly document in the medical record past medical and surgical history, as well as all surgical and diagnostic procedures. Include dates and results.
- Use correct diagnosis and procedure codes.
- Submit claims and encounter data in a timely manner.

How to Document

The medical record must **include the date the screening was performed**. Results or findings aren't required if the screening documentation is clear in the medical history. If the documentation isn't clear, screening results must be included to demonstrate that the screening was performed, not merely ordered.

Acceptable forms of documentation include:

- Member-reported **colorectal cancer screening documented in the medical history** (e.g., member reports normal colonoscopy in 2023)
- **Pathology report** indicating the type of screening, such as colonoscopy or flexible sigmoidoscopy, and screening date
- FOBT, depending on the number of samples and type of test: guaiac (gFOBT) or immunochemical (FIT)
  - **FIT** meets the screening criteria regardless of how many samples were returned.
  - **gFOBT** meets the screening criteria if the medical record indicates three or more samples were returned, or if the medical record doesn't include the number of returned samples. In this case, it is assumed three or more were returned. Fewer than three samples don't meet the screening criteria.
  - If the medical record doesn't indicate the type of test (gFOBT or FIT), the screening criteria are met if the record specifies three or more samples were returned, or if it doesn't include the number of returned samples. In this case, it is assumed the required samples were returned.

For more information, see **NCQA's HEDIS Measures and Technical Resources**.

Questions?

Contact your Network Representative.