Measure Name	Colorectal Cancer Screening
Relevance	NPO Population Clinical Data Dashboard [NQF 0034: Prevention & Screening Measure]  ACO Quality Measure #19 [GPRO: Preventive Measure]  MIPS Clinical Quality Measure (CMS 130 (EHR)/Registry 113: Process Measure]
Measure Definition	The percentage of patients, 50-75 years of age, who received appropriate screening for colorectal cancer
Measurement Period	The <b>Measurement Period</b> is defined as the current calendar year (January 1 - December 31)
Denominator	The <b>Denominator</b> consists of patient who:  I. Are ≥ 50 and < 75 years old at the start of the Measurement Period  II. <b>AND</b> , Had an applicable E&M encounter during the Measurement Period
Numerator	The Numerator consists of patients, from the Denominator, who have been screened for colorectal cancer by one of the following methods:  1. A Fecal Occult Blood Test (FOBT) performed during the Measurement Period  11. A FIT-DNA (Cologuard) test performed either:  A. Within the Measurement Period  B. Or, Within the two years prior to the Measurement Period  11. A Colonoscopy performed either:  A. Within the Measurement Period  B. Or, Within the Measurement Period  Continued)

Measure Name	Colorectal Cancer Screening (continued)
Numerator (continued)	<ul> <li>IV. A Flexible Sigmoidoscopy performed either: <ul> <li>A. Within the Measurement Period</li> <li>B. Or, Within the four years prior to the Measurement Period</li> </ul> </li> <li>V. A CT Colonography performed either: <ul> <li>A. During the Measurement Period</li> <li>B. OR, Within the 4 years prior to the Measurement Period</li> </ul> </li> <li>Note: The analysis of stool collected during a digital rectal exam does not qualify as an appropriate colorectal cancer screen and does NOT satisfy this measure</li> </ul>
Exclusions and/or Exceptions	Patients are <b>excluded/excepted</b> from the Denominator for one of the following reasons:  I. They have had a diagnosis (active, inactive, or resolved) for Malignant Neoplasm of the Colon before the end of the Measurement Period  II. They have had a total colectomy performed before the end of the Measurement Period
Measure Documentation	To Qualify For this Measure (Denominator Documentation)  I. The patient must be seen for an applicable encounter during the Measurement Period  A. The following E&M codes identify applicable visit enounters  1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99385 - 99387 and 99395 - 99397  (continued)

Measure Name	Colorectal Cancer Screening (continued)
Measure Name  Measure  Documentation  (continued)	Solorectal Cancer Screening (continued)  3. G0438 and G0439  B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit (Progress Notes → Billing)  II. If applicable, document FOBT results in the "Labs" section of the patient's chart in eCW  A. If the FOBT Test lab order has been electronically-generated and resulted in your EMR, no further action is necessary  B. Otherwise, manually generate the lab order and/or enter the lab result, as follows:  1. Access the "Labs" section of the patient's chart 2. If necessary, click "New" to create a new Lab order  a. Click the "SEL" button, adjacent to the "Lab" search field b. Find and select the appropriate FOBT lab from the list of Lab options  3. Complete the following fields:
(continuea)	3. Complete the following fields:  a. Order Date
	1) If pagassary enter the data the lab was ordered
	<ol> <li>If necessary, enter the date the lab was ordered</li> <li>Hint: if you do not know the order date, enter the date the test was performed</li> </ol>
	b. <b>Collection Date</b>
	(MANDATORY)  1) Check the box in the "Collection Date" field
	2) Enter the date the sample was collected
	3) Hint: If you do not know the collection date, enter the date the test was performed
	(continued)

Measure Name	Colorectal Cancer Screening (continued)
	c. <b>Results</b>
	(MANDATORY)  1) Check the "Received" box in the Results section  (MANDATORY)  2) Enter the date the test was performed  (MANDATORY)  3) Type the result (Positive or Negative) in the yellow grid  (MANDATORY)  d. Reviewed: Check the "Reviewed" box
	III. If applicable, document Cologuard results in the "Labs" section of the patient's chart in eCW
	A. The Cologuard lab must first be manually-entered into the Lab compendium in your EMR
	<ol> <li>From the EMR menu within eCW, select "Labs, DI &amp; Procedures"</li> <li>Select "Labs" from the list of options</li> </ol>
Measure	3. The "Labs" window will open
Documentation (continued)	<ul> <li>a. Click the "New" button at the bottom of the window</li> <li>b. A "Lab New Item/Category" window will open</li> <li>c. Type "Cologuard" into the "Name" field</li> <li>d. Click "OK"to close the window</li> </ul>
	4. Click the "Attribute Codes" button
	a. A new window will open b. Click the "Update LOINC" button c. The "Associate LOINC with Test" window will open  1) Enter the LOINC code 77354-9 into the LOINC search field 2) Click "OK"  5. The Cologuard lab will need to be mapped to a Community element in your EMR  (continued)

Measure Name	Colorectal Cancer Screening (continued)
Measure Documentation (continued)	a. From within eCW, click the "Community" tab in the top menu bar b. Select "Mappings" c. Select "Labs" from the drop-down menu of options d. The "Community Lab Mapper" window will open  1) Find and select "Cologuard" on the Community side 2) If Cologuard is not available on the Community side, log a ticket with eCW to have it added 3) Find and select "Cologuard" on the Local side 4) Click "Map"  B. Cologuard results must be manually-entered into a newly-created Lab order  1. Access the "Labs" section of the patient's chart 2. Click "New" to create a new lab order 3. Click the "SEL" button associated with the Lab name field 4. Find and select the Cologuard lab from the list of Lab options 5. Complete the remaining fields as detailed (for FOBT), above  IV. If applicable, document Colonoscopy results in the "DI" (Diagnostic Imaging) section of the patient's chart in eCW  A. Colonoscopy results must be manually-entered into a newly-created DI order  1. Access the "DI" section of the patient's chart 2. If necessary, click "New" to generate a new DI order  a. Click the "SEL" button adjacent to the DI name field
	<ul> <li>a. Click the "SEL" button adjacent to the DI name field</li> <li>b. Find and select the appropriate Colonoscopy test from the list of DI options</li> <li>3. Complete the following fields:</li> </ul>
	(continued)

Measure Name	Colorectal Cancer Screening (continued)
	a. Order Date
	<ol> <li>Enter the date the test was ordered</li> <li>Hint: if you do not know the order date, enter the date the test was performed</li> </ol>
	b. Collection Date
	(MANDATORY)  1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected
	3) Hint: If you do not know the collection date, enter the date the test was performed
	c. <b>Results</b>
	(MANDATORY)  1) Check the "Received" box in the Results section
Measure	(MANDATORY) 2) Enter the date the test was performed
Documentation (continued)	<ol> <li>Select an option from the "Results" drop-down box (e.g., Positive or Negative, Normal or Abnormal)</li> </ol>
	(MANDATORY) d. Reviewed: Check the "Reviewed" box
	B. The MIPS version of this measure may also satisfied by recording a specific CPT or HCPCS code for the Colonoscopy procedure
	1. The following CPT or HCPCS codes identify a Colonoscopy procedure
	a. 44388 - 44394 and 44397
	b. 45355, 45378 - 45387 and 45391 - 45392
	c. G0105 and G0121
	2. Document the CPT or HCPCS code from one of the following locations in a Progress Note
	a. $Progress\ Note  ightarrow Treatment  ightarrow Procedures$
	(continued)

Measure Name	Colorectal Cancer Screening (continued)
	<ul> <li>b. Progress Note → Billing</li> <li>V. If applicable, document Flexible Sigmoidoscopy results in the "DI" (Diagnostic Imaging) section of the patient's chart in eCW</li> </ul>
	A. Flexible Sigmoidoscopy results must be manually-entered into a newly-created DI order
	1. Access the DI section of the chart
	2. Click "New" to generate a new DI order
	a. Click the "SEL" button adjacent to the DI name field
	b. Find and select the appropriate Flexible Sigmoidoscopy test from the list of DI options
	3. Complete the remaining fields as detailed (for Colonoscopy), above
Measure Documentation (continued)	B. The MIPS version of this measure may also satisfied by recording a specific CPT or HCPCS code for the Flexible Sigmoidoscopy procedure
,	1. The following CPT or HCPCS codes identify a Flexible Sigmoidoscopy procedure
	a. 45330 - 45335, 45337 - 45339, 45340 - 45342 and 45345 b. G0104
	2. Document the CPT or HCPCS code from one of the following locations in a Progress Note
	a. $Progress\ Note  ightarrow Treatment  ightarrow Procedures$ b. $Progress\ Note  ightarrow Billing$
	VI. If applicable, document CT Colonography results in the "DI" (Diagnostic Imaging) section of the patient's chart in eCW
	A. The CT Colonography test must first be manually-entered into the DI compendium in your EMR
	(continued)

Measure Name	Colorectal Cancer Screening (continued)
ivicusure nume	<ol> <li>From the EMR menu within eCW, select "Labs, DI &amp; Procedures"</li> <li>Select "Diagnostic Imaging" from the list of options</li> <li>The "Diagnostic Imaging" window will open</li> <li>a. Click the "New" button at the bottom of the window</li> <li>b. A "Lab New Item/Category" window will open</li> <li>c. Type "CT Colonography" into the "Name" field</li> <li>d. Click "OK" to close and return to the Diagnostic Imaging window</li> <li>From the Diagnostic Imaging window, find and select the newly-created "CT Colonography" DI</li> </ol>
Measure Documentation (continued)	<ul> <li>a. Click the "Associate CPTs" button</li> <li>b. The "Associate CPTs" window will open</li> <li>c. Click the "Add" button</li> <li>d. Type "CT Colonography" into the search field of the new window that opens</li> <li>e. Select the appropriate CPT code from the list of options and click "Apply"</li> <li>f. The following CPT codes identify CT Colonography procedures</li> </ul>
	<ol> <li>74261 (CT Colonography without Dye)</li> <li>74262 (CT Colonography with Dye)</li> <li>74263 (CT Colonography Screening)</li> </ol>
	5. To map the test to it's Community counterpart, click the "Community" tab in the top menu bar
	<ul> <li>a. Select "Mappings"</li> <li>b. Select "Diagnostic Imaging"</li> <li>1) A Diagnostic Imaging "Mapper" window will open</li> <li>2) Find and select "CT Colonography on both the Community and Local sides</li> <li>3) Click "Map"</li> <li>4) Note: If "CT Colonography" is not present on the Community side, log a ticket with eCW to</li> </ul>

Measure Name	Colorectal Cancer Screening (continued)
Measure Documentation (continued)	<ul> <li>have it added</li> <li>B. The CT Colonography test results will need to be manually-entered into a newly-created DI order in the "Diagnostic Imaging" section of the patient's chart</li> <li>1. Follow the procedure detailed above (for Colonoscopy)</li> <li>2. Attach a copy of the CT Colonography report to the patient's chart (i.e., scan it into the "Patient Documents" section of the patient's chart</li> </ul>
Exclusion and/or Exception Documentation (continued)	To Exclude Patients From This Measure (Exclusion and/or Exception Documentation)  I. Exclude patients with a diagnosis (active, inactive, or resolved) for Malignant Neoplasm of the Colon by the end of the Measurement Period  A. The following ICD-10 codes identify a Malignant Neoplasm of the Colon  1. C18.0 - C18.9 and C19 2. C20, C21.0 - C21.2 and C21.8 3. C78.5  B. Record the ICD-10 code in the Problem List of the patient's chart in eCW
	<ul> <li>II. Exclude patients that have had a Total Colectomy performed before the end of the Measurement Period</li> <li>A. The following CPT codes identify a Total Colectomy procedure: 44150 - 44158 and 44210 - 44212</li> <li>B. Record the CPT code in one of the following locations of a Progress Note (or Virtual Visit)</li> <li>1. Progress Notes → Treatment → Procedures         <ul> <li>(continued)</li> </ul> </li> </ul>

Measure Name	Colorectal Cancer Screening (continued)
Exclusion and/or Exception Documentation (continued)	2. Progress Notes → Billing
	Having Problems? Check Out the Following Trouble-Shooting Tips
	I. Verify that the correct LOINC code is attached to the FOBT and Cologuard labs
	A. The following LOINC codes identify the FOBT lab:
	1. 12503-9, 12504-7, 14563-1, 14564-9 and 14565-6
	2. 2335-8, 27396-1, 27401-9, 27925-7, 27926-5 and 29771-3
	3. 56490-6, 56491-4, 57905-2 and 58453-2
	B. The following LOINC code identifies the Cologuard lab: 77354-9
Trouble-Shooting	II. Verify that all mandatory fields have been completed for all manually-entered Labs and DIs
	A. For the FOBT and Cologuard Labs:
	I.e., Verify that the "Collection Date" box has been checked
	2. I.e., Verify that the (Results) "Received" box has been checked
	3. I.e., Verify that a "Results" date has been entered
	4. I.e., Verify that the Result has been entered in the yellow grid
	5. I.e., Verify that the "Reviewed" box has been checked
	B. For the Colonoscopy, Flexible Sigmoidoscopy, and CT Colonography DIs:
	1. I.e., Verify that the "Performed Date" box has been checked
	2. I.e., Verify that the (Results) "Received" box has been checked
	3. I.e., Verify that a "Results" date has been entered
	(continued)

Measure Name	Colorectal Cancer Screening (continued)
Trouble-Shooting (continued)	<ol> <li>I.e., Verify that the Result has been entered in the "Result" field</li> <li>I.e., Verify that the "Reviewed" box has been checked</li> </ol>
	III. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
	For More Information
For More Information	I. NQF 0034: "Colorectal Cancer Screening"
	II. eClinicalWorks "MIPS - CMS 130- Colorectal Cancer Screening "
	III. eClinicalWorks "MIPS - PQRS 113 (NQF 0034) (MIPS - CMS 130) - Colorectal Cancer Screening"
	IV. 2016 GPRO PREV Supporting Documents