# Colorectal Cancer Screening (CMS130)

The following is for educational purposed only and is not intended to be clinical or legal advice. The information provided in the Measure Details section is based on specification published by CMS at https://ecqi.healthit.gov/ecqm/ec/2023/cms130v11

## Measure Details

### Description *

Percentage of adults ~~50~~ 45-75 years of age who had appropriate screening for colorectal cancer

### Initial Population

Percentage of adults ~~50~~ 45-75 years of age who had by the end of the measurement period with a visit during the measurement period

### Denominator

Equals Initial Population

### Numerator

Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period
- FIT-DNA during the measurement period or the two years prior to the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- CT Colonography during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period
- ~~FIT-DNA during the measurement period or the two years prior to the measurement period~~
- ~~CT Colonography during the measurement period or the four years prior to the measurement period~~

### Denominator Exclusion

- Exclude patients who are in hospice care for any part of the measurement period
- Exclude patients receiving palliative care ~~during~~ for any part of the measurement period.
- Exclude patients with a diagnosis or past history of total colectomy or colorectal cancer
- Exclude patients 66 and older by the end of the measurement period who are living long term in ~~an institution for more than 90 consecutive days during~~ a nursing home any time on or before the end of the measurement period
- Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
    - Advanced illness with two outpatient encounters during the measurement period or the year prior – OR
    - Advanced illness with one inpatient encounter during the measurement period or the year prior – OR Taking dementia medications during the measurement period or the year prior

### Numerator Exclusion

NA

## Overview

| What is Documented | When is it Documented | Where in QMER |
|---|---|---|
| Qualifying Encounter | During Measurement Period (2023) | Coded SOAP Note |
| FOBT | During Measurement Period (2023) | Orders & Results |
| FIT-DNA | During Measurement Period (2023) or two years prior | Orders & Results |
| Flexible Sigmoidoscopy | During Measurement Period (2023) or four years prior | Orders & Results |
| CT Colonography | During Measurement Period (2023) or four years prior | Orders & Results |
| Colonoscopy | During Measurement Period (2023) or nine years prior | History Module |

| Exclusions/Exceptions | Where in QEMR |
|---|---|
| Patients with a History of Total Colectomy | History Module |
| Patients with a History of Colorectal Cancer | History Module |
| Patients who are in hospice care for any part of the measurement period | History Module |
| Patients receiving palliative care for any part of the measurement period | History Module |
| Patients 66 years and old living long term in a nursing home on or before the measurement period | History Module |
| Patients 66 years and older with an indication of frailty during the measurement period and<br>○ Advanced illness with two outpatient encounters during the measurement period or the year prior – OR<br>○ Advanced illness with one inpatient encounter during the measurement period or the year prior – OR<br>○ Taking dementia medications during the measurement period or the year prior | |

| 2022 to 2023 Changes |
|---|
| Initial population age range has changed to 45-75 years, previously 50-75 |

## Set Up

All codification shown is an example for incrementation, for a full list of accepted codes please visit Value Set Authority Center.

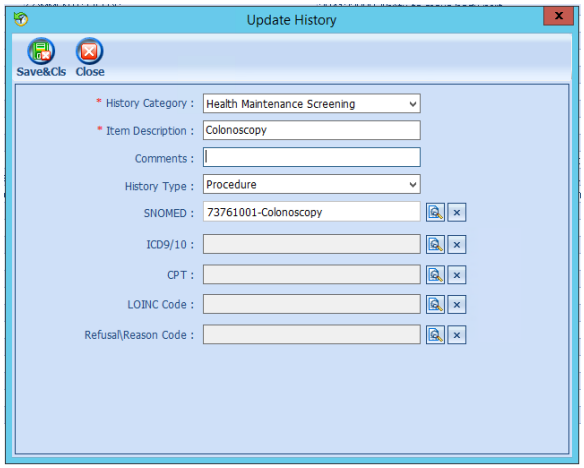
### Qualifying Encounter

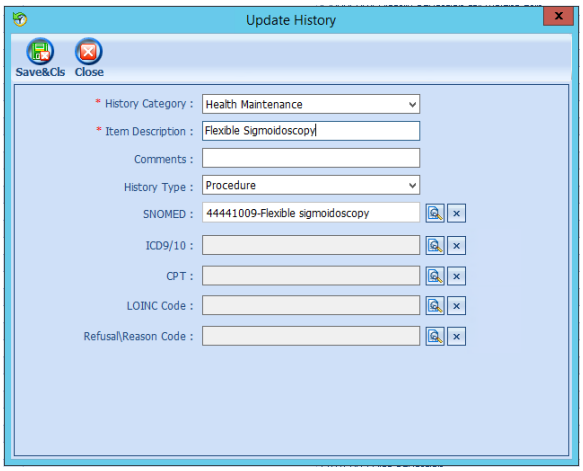
No set up required

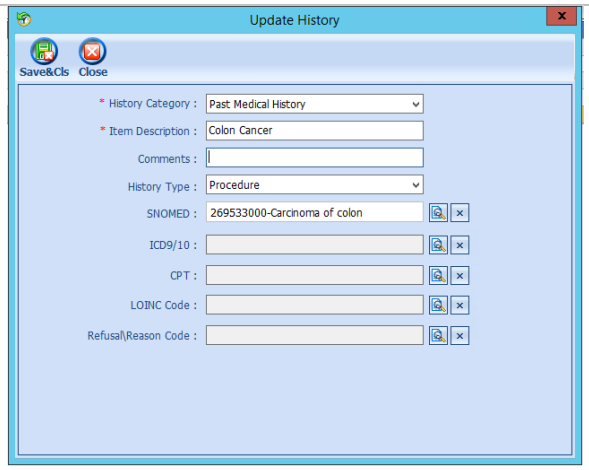
## Building History Items (Colonoscopy, Flx. Sig., Hx of Colon CA, Hospice Care & Palliative Care)

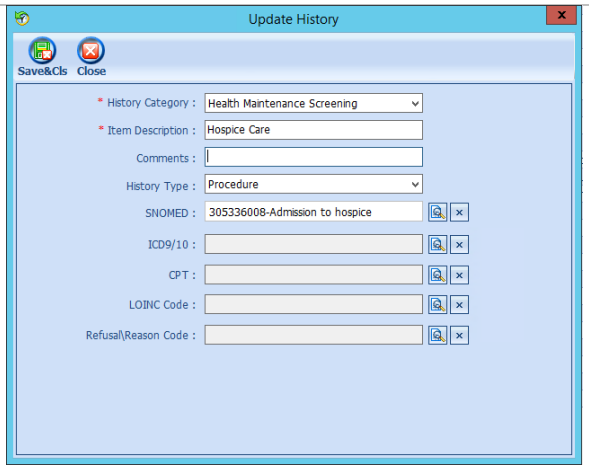
Build the history items below:

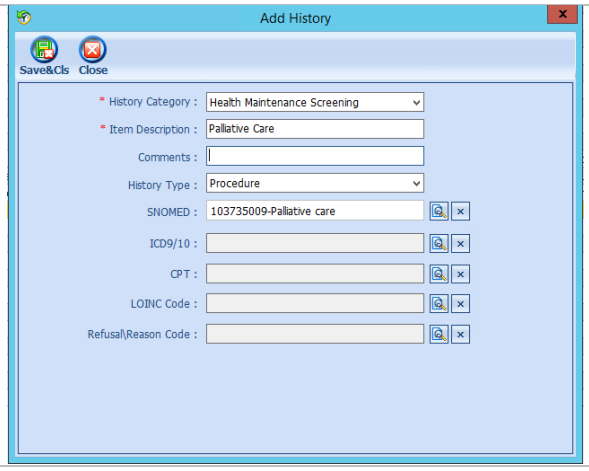
1. Log into **QEMR** > Navigate to **Edit** > **History**
2. Highlight ***desired*** **History Category** list on left side bar
3. Click **New** hot button
4. **Complete the Update History** Screen as seen below
5. Click **Save & Close** hot button

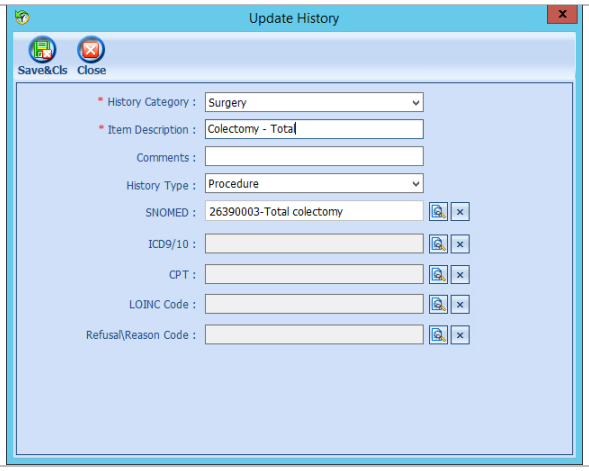


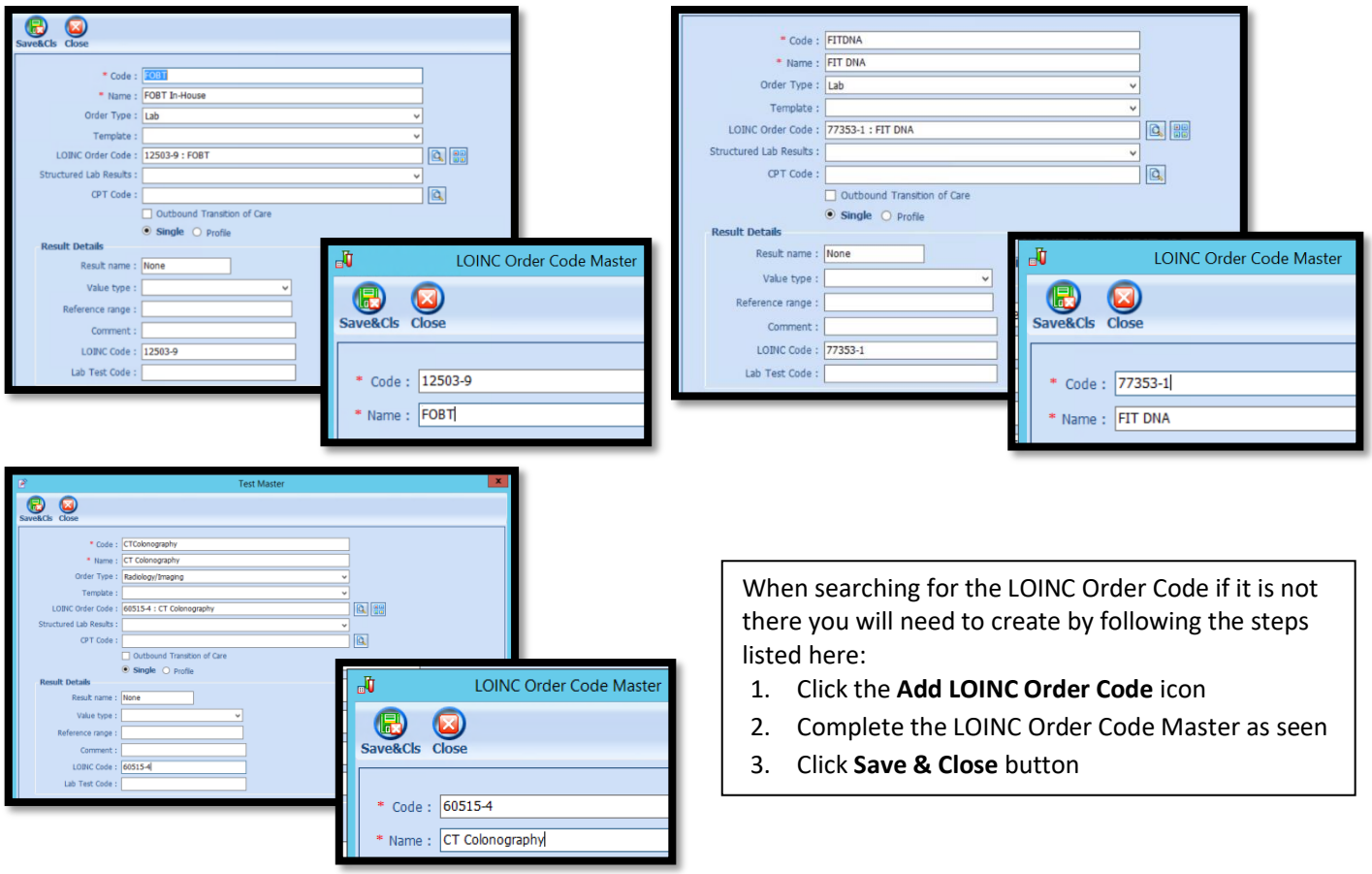



## Internal Orders & Results (FOBT, FIT FNA & CT Colonography)

If the test is ordered via Lab Interface, the resulting lab should be sending LOINC in the HL7 message. If resulted internally (in office lab test), build the appropriate result profile in **Edit > Orders & Results**, adding appropriate LOINC (from lab test kit).

1. Log into **QEMR** > Navigate to **Edit** > **Order & Results Setup > New** hot button
2. Complete the Test Master screen as shown below using appropriate LOINC
3. Click Save & Close




When searching for the LOINC Order Code if it is not there you will need to create by following the steps listed here:

1. Click the **Add LOINC Order Code** icon
2. Complete the LOINC Order Code Master as seen
3. Click **Save & Close** button

# Workflow

## Qualifying Encounter

Following standard office workflow, document patient visit(s) via SOAP notes and code with CPT and diagnosis codes using either DxCPT, SmartDx or Smart CPT modules.

## Document History Items Colonoscopy, Flx. Sig., Hx of Colon Cancer, Hospice Care or Palliative Care

To document smoking status, follow steps below:

1. Navigate to **History** Module > **applicable History** category
    a. Double-click applicable History Item
        i. Non-Smoker OR
        ii. Tobacco User
    b. Enter **Occur Date**

| Category | Item | Comments | Smoking Status | Active | Occur Date | Date Entered | Source |
|---|---|---|---|---|---|---|---|
| Health Maintenance Screening | | | | | | | |
| | Colonoscopy | | | | 05/10/2021 | 1/13/2022 6:18 PM | gloEMR |

| Category | Item | Comments | Smoking Status | Active | Occur Date | Date Entered | Source |
|---|---|---|---|---|---|---|---|
| Health Maintenance Screening | | | | | | | |
| | Flexible Sigmoidoscopy | | | | 01/13/2018 | 1/13/2022 6:20 PM | gloEMR |

| Past Medical History | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Colon Cancer | | | | 01/13/2015 | 1/13/2022 6:21 PM | gloEMR |

| Category | Item | Comments | Smoking Status | Active | Occur Date | Date Entered | Source |
|---|---|---|---|---|---|---|---|
| Surgical History | | | | | | | |
| | Colectomy - Total | | | | 01/13/2010 | 1/13/2022 6:22 PM | gloEMR |

| Category | Item | Comments | Smoking Status | Active | Occur Date | Date Entered | Source |
|---|---|---|---|---|---|---|---|
| Health Maintenance Screening | | | | | | | |
| | Hospice Care | | | | 01/04/2022 | 1/13/2022 6:24 PM | gloEMR |

| Category | Item | Comments | Smoking Status | Active | Occur Date | Date Entered | Source |
|---|---|---|---|---|---|---|---|
| Health Maintenance Screening | | | | | | | |
| | Palliative Care | | | | 05/09/2022 | 10/13/2022 10:15 AM | gloEMR |

## Document Tests FOBT, FIT DNA or CT Colonography

### *Ordering Test*

For those who order or perform the testing without a lab interface order and results must be done via the **Orders & Results > Order Entry**

1. Navigate to **Orders & Results > Order Entry** hot button
2. Double-click **FOBT, FIT DNA or CT Colonography**
    a. To modify and/or print the prescription for the patient click the ellipsis icon for templates
    b. **Modify** Template if necessary > **Print** > **Save & Close**
3. **Save & Close** the order Entry Screen > **Save & Close** the View Orders and Results Screen

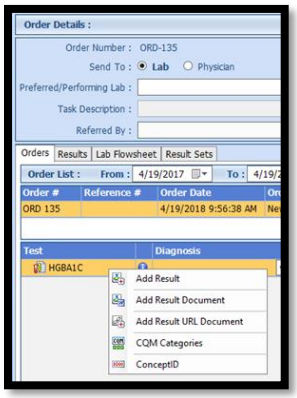
### *Test Results*

After receiving the test results via scanned documents or received fax you must associate it with the order or manually enter the numerical results if testing was done in-house.

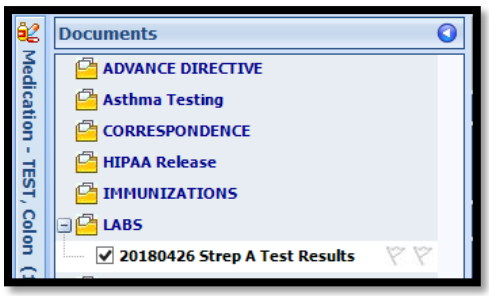
### *Adding Scanned Results*

To associate a document to the test results:

1. Navigate to **Orders & Results > Orders Tab**
2. Right-click on the test you would like to add the results to
3. Click **Add Results Document**




4. You will be brought to the **Scan Documents** screen
    a. Place a **check box** in the document you would like to associate
    b. Click **Save** hot button




### *Adding Value Results to Order*

To manually document the test results:

1. Navigate to **Orders & Results > Orders Tab**
2. Right-click on the test you would like to add the results to
3. Click **Add Results**
4. Enter test results in **Value** field **>** Click **Save & Close** hot button

# Incrementing Details

## Occur Dates

To increment ANY measure using the History Module the Occur Dater MUST be documented using appropriate date based upon Measure Description.

## Exam Coding

If exam notes (Past Exams) are not coded with Diagnosis Code and CPT code measures will not increment.

## Measure Specific Codes

The codification shown in this document are examples of qualifying documentation. To see a full list please visit Value Set Authority Center.

# CMS Guidance *

Do not count digital rectal exams (DRE), fecal occult blood tests (FOBTs) performed in an office setting or performed on a sample collected via DRE.