

HEDIS 2015 CRITERIA

Colorectal Cancer Screening (COL)



Q: Which members are included in the sample?

A: Members 50-75 years of age who had appropriate screening for colorectal cancer.

Q: What codes are used?

A: Please reference Value Set Directory

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a note indicating the **date** the colorectal cancer screening was performed. Appropriate screenings are defined by **any** of the following:

- Fecal occult blood test in 2014; either guaiac (gFOBT) or immunochemical (iFOBT)
- Flexible sigmoidoscopy performed in 2010, 2011, 2012, 2013 or 2014
- Colonoscopy in 2014 or within 9 years prior to 2014.

Q: What type of medical record is acceptable?

A: One or more of the following:

- Health Maintenance Form
- Progress notes/Office visits notes
- Problem List
- Laboratory/Pathology Reports
- Medical History Forms
- Complete Physical Examination Form
- X-ray Reports
- GI Consults/Reports/Flow Charts

Q: How to improve score for this HEDIS measure?

A:

- Use of complete and accurate Value Set
- Timely submission of claims and encounter data
- Ensure presence of ALL components in the medical record documentation

Exclude members with diagnosis of colorectal cancer or total colectomy
(use designated Value Set for each)