2013 DATA COLLECTION GUIDE

Summary Data Submission

Colorectal Cancer Screening

(07/01/2012 to 06/30/2013 Dates of Service)
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**Hotline:** 612-746-4522 | **E-mail:** support@mncm.org | **Data Portal:** https://data.mncm.org/login

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Colorectal Cancer Screening
2013 Summary Data Submission
(07/01/2012 to 06/30/2013 Dates of Service)

Measure Specifications
## Summary of Changes

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<tr>
<td><strong>Date of birth clarification</strong></td>
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<tr>
<td>Added language to clarify date of birth range. Please note the changes in the denominator section.</td>
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<table>
<thead>
<tr>
<th>CT Colonography Codes</th>
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<tr>
<td>Added CT Colonography codes to assist in identifying patients who have undergone a CT colonography procedure.</td>
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<table>
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<tr>
<th>Updated Coding Tables</th>
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<tbody>
<tr>
<td>Updated coding tables to align with 2013 HEDIS Specifications for Colorectal Cancer Screening.</td>
</tr>
</tbody>
</table>

For identifying the diagnosis of colon cancer for exclusion, removed the following ICD-9 codes:
- V76.41 Special screening for malignant neoplasm; other sites; rectum
- V76.50 Special screening for malignant neoplasm; intestine; intestine, unspecified and previous instruction “Only use these codes if the screening did not find colorectal cancer”
- 154.8 Malignant neoplasm of rectum, rectosigmoid junction, and anus; Other
- V10.06 Personal history of malignant neoplasm; Gastrointestinal tract; Rectum, rectosigmoid junction, and anus

For identifying patients with total colectomy, removed the following ICD-9 code:
- 45.92 Anastomosis of small intestine to rectal stump

Added detail for individual ICD-9 codes in the range of 153.0x Malignant neoplasm of the colon.

## Description

This measure captures the percentage of patients who are up to date with appropriate colorectal cancer screening exams.

## Methodology

Population identification is accomplished via a query of a practice management system or Electronic Medical Record (EMR) to identify the population of eligible patients (denominator). Data elements are either extracted from an EMR system or abstracted through medical record review. Clinics that had an EMR in place by 07/01/2011 are required to submit data on their full population.
### Rationale
Cancer of the colon and rectum is one of the most prevalent forms of cancer and one of the top three leading causes of cancer-related deaths for both men and women. The burden of colorectal cancer rests primarily in older adults. Over 75% of all deaths due to colorectal cancer occur in adults over the age of 65. At an aggregated level, about 6% of all Americans will be diagnosed with colorectal cancer at some point in their lives, but specific populations will be affected at different rates with men more likely to acquire than women, rural populations having higher incidence rates than urban and American Indian populations seeing incidence rates far greater than other race/ethnicity groups. The colorectal cancer screening measure currently reported by Minnesota Community Measurement comes from the NCQA’s HEDIS® colorectal cancer screening rate measure. The measure reports the percentage of patients at a medical group who have received colorectal cancer screening within a 12 month period by capturing the entire population ages 50 to 80 with screening tests either within the reporting period or in the medical history as dictated by the test type. Populations not represented by the current rate include patients who have Medicaid insurance and Medicare Fee For Service patients. Unlike many cancers, colorectal cancer develops in a largely predictable progressive pattern where a small tissue growth in the large intestine can turn cancerous over a period of several months to several years. Screening for colorectal cancer to identify and remove these growths is believed to account for the biggest potential reduction in mortality rates. Preventing the incidence and mortality for colorectal cancer has been a key focus of several state and nationwide initiatives including Healthy People 2010, the Minnesota Cancer Alliance, and the American Cancer Society.

This measure has the following benefits: a) Can capture screening rates at a clinic site level; b) Can more appropriately capture the entire patient population in a clinic’s case mix by including Medicare Fee For Service and Medicaid patients; and c) Will potentially allow for a real impact on the burden and mortality of colorectal cancer due to early detection and prevention associated with increased screening.

### Measurement Period
Measurement period will be a fixed twelve month period: 07/01/2012 to 06/30/2013.
### Denominator

Established patient who meets each of the following criteria is included in the population:

- Patient was age 51 to 75 at the end of the measurement period (date of birth was on or between 06/30/1937 to 6/30/1962).
- Patient was seen by an eligible provider in an eligible specialty face-to-face at least two times during the last two years (07/01/2011 to 06/30/2013). Use this date of service range when querying the practice management or EMR system to allow a count of the visits within this time frame.
- Patient was seen by an eligible provider in an eligible specialty face-to-face at least one time during the last twelve months (07/01/2012 to 06/30/2013).

**Eligible specialties:** Family Medicine (includes General Practice), Internal Medicine, Geriatric Medicine, Obstetrics/Gynecology.

**Eligible providers:** Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP).

### Allowable exclusions

- Patient was in hospice at any time during the measurement period.
- Patient died prior to the end of the measurement period.
- Patient with history of any of the following diagnoses:
  - Total colectomy (ICD-9 procedure codes 45.81, 45.82, 45.83 and/or CPT procedure codes 44150-44153, 44155-44158, 44210-44212).
  - Colorectal cancer (ICD-9 diagnosis codes 153, 154.0, 154.1, 197.5, V10.05 and/or HCPCS codes G0213, G0214, G0215, G0215, G0231).
- Patient had a CT Colonography (CPT procedure codes 74261, 74262, 74263, 0066T and 0067T) screening examination performed in the measurement period during the last twelve months (07/01/2012 to 06/30/2013) or four years prior to the measurement period (07/01/2008 to 06/30/2013).

### Numerator

The number of patients who were up to date with appropriate colorectal cancer screening exams. Appropriate exams include colonoscopy, sigmoidoscopy, or fecal blood tests as outlined below:

- **COLONOSCOPY within the measurement period or prior nine years (Valid dates = 07/01/2003 to 06/30/2013).**
  - Using claims codes: Provide the service date associated with the codes for a colonoscopy.
    - Accepted colonoscopy CPT procedure codes: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392.
    - Accepted colonoscopy ICD-9 procedure codes: 45.22, 45.23, 45.25, 45.42, 45.43.
    - Accepted colonoscopy HCPCS codes: G0105, G0121.
  - OR
    - Using an EMR: Provide the date field associated with the date of the colonoscopy procedure.
Note: Date of referral-only not accepted, providers must be able to produce documentation that the colonoscopy was completed (e.g. consult letter, procedure note, or patient self-report).

A) SIGMOIDOSCOPY within the measurement period or prior four years (Valid dates = 07/01/2008 to 06/30/2013).
   • Using claims codes: Provide the service date and code associated with the sigmoidoscopy procedure.
     o Accepted sigmoidoscopy CPT procedure codes: 45330-45335, 45337-45342, 45345.
     o Accepted sigmoidoscopy ICD-9 procedure codes: 45.24.
     o Accepted sigmoidoscopy HCPCS codes: G0104.
   OR
   • Using an EMR: Provide the date field associated with the date of the sigmoidoscopy procedure.
     Note: Date of referral-only not accepted, providers must be able to produce documentation that the colonoscopy was completed (e.g. consult letter, procedure note, or patient self-report).

B) STOOL BLOOD TESTS within the measurement period (07/01/2012 to 06/30/2013).
   • Acceptable stool tests: guaiac FOBT (gFOBT) and fecal immunochemical test (FIT).
   • Must be done within the measurement period (valid dates = 07/01/2012 to 06/30/2013).
   • Using claims codes: Provide service date and code associated with the stool test.
     o Accepted CPT procedure codes: 82270, 82274.
     o Accepted HCPCS codes: G0328.
     o Accepted LOINC codes: 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2.
   OR
   • Using an EMR: Provide the name of the test used and date field associated with the date of the order of the stool test.
Coding Conventions Used in MN Community Measurement Documentation

MNCM uses the standard HEDIS coding conventions from HEDIS 2013, *Colorectal Cancer Screening*. Where there are modifiers after the codes and all modifiers are applicable and required for specificity, an X is used to indicate the required modifier. For example, an acceptable exclusion for this measure is a patient with colon cancer. The ICD-9 diagnosis code 153 is the code for, “Malignant neoplasm of colon,” and the specifications below indicate that 153.X ICD-9 diagnosis codes are acceptable. This includes all the ICD-9 diagnosis codes under 153: 153.0, 153.1, 153.2, etc. This coding convention is used to describe ranges of codes, please refer to the tables included for the complete list of codes.

Colorectal Cancer Screening Test Codes

Table 1: CPT Procedure Codes for Identifying Colonoscopies

<table>
<thead>
<tr>
<th>CPT Procedure Code</th>
<th>CPT Procedure Code Description</th>
</tr>
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<tbody>
<tr>
<td>44388</td>
<td>Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</td>
</tr>
<tr>
<td>44389</td>
<td>Colonoscopy through stoma; with biopsy or multiple</td>
</tr>
<tr>
<td>44390</td>
<td>Colonoscopy through stoma; with removal of foreign body</td>
</tr>
<tr>
<td>44391</td>
<td>Colonoscopy through stoma; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)</td>
</tr>
<tr>
<td>44392</td>
<td>Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery</td>
</tr>
<tr>
<td>44393</td>
<td>Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>44394</td>
<td>Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
</tr>
<tr>
<td>44397</td>
<td>Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)</td>
</tr>
<tr>
<td>45355</td>
<td>Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple</td>
</tr>
<tr>
<td>45378</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brush or washing, with or without colon decompression</td>
</tr>
<tr>
<td>45379</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body</td>
</tr>
<tr>
<td>45380</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple</td>
</tr>
<tr>
<td>45381</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance</td>
</tr>
<tr>
<td>45382</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)</td>
</tr>
<tr>
<td>45383</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>45384</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery</td>
</tr>
<tr>
<td>45385</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
</tr>
</tbody>
</table>
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<tr>
<th>CPT Procedure Code</th>
<th>CPT Procedure Code Description</th>
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<tr>
<td>45386</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures</td>
</tr>
<tr>
<td>45387</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)</td>
</tr>
<tr>
<td>45391</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination</td>
</tr>
<tr>
<td>45392</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)</td>
</tr>
</tbody>
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Table 2: ICD-9 Procedure Codes for Identifying Colonoscopies

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<th>ICD-9 Procedure Code</th>
<th>ICD-9 Procedure Code Description</th>
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</thead>
<tbody>
<tr>
<td>45.22</td>
<td>Endoscopy of large intestine through artificial stoma</td>
</tr>
<tr>
<td>45.23</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td>45.25</td>
<td>Closed [endoscopic] biopsy of large intestine</td>
</tr>
<tr>
<td>45.42</td>
<td>Endoscopic polypectomy of large intestine</td>
</tr>
<tr>
<td>45.43</td>
<td>Endoscopic destruction of other lesion or tissue of large intestine</td>
</tr>
</tbody>
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Table 3: HCPCS Codes for Identifying Colonoscopies

<table>
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<tr>
<th>HCPCS Code</th>
<th>HCPCS Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0105</td>
<td>Colorectal cancer screening; colonoscopy on individual at high risk</td>
</tr>
<tr>
<td>G0121</td>
<td>Screening colonoscopy, patients at average risk</td>
</tr>
</tbody>
</table>

Table 4: CPT Procedure Codes for Identifying Sigmoidoscopies

<table>
<thead>
<tr>
<th>CPT Procedure Code</th>
<th>CPT Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45330</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</td>
</tr>
<tr>
<td>45331</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with biopsy, single or multiple</td>
</tr>
<tr>
<td>45332</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of foreign body</td>
</tr>
<tr>
<td>45333</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery</td>
</tr>
<tr>
<td>45334</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with control of bleeding (e.g. Injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)</td>
</tr>
<tr>
<td>45335</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with directed submucosal injection(s), any substance</td>
</tr>
<tr>
<td>45337</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with decompression of volvulus, any method</td>
</tr>
</tbody>
</table>
| 45338              | Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of tumor(s), polyp(s), or other lesion(s) by
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<table>
<thead>
<tr>
<th>CPT Procedure Code</th>
<th>CPT Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45339</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare techniques</td>
</tr>
<tr>
<td>45340</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with dilation by balloon, 1 or more strictures</td>
</tr>
<tr>
<td>45341</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with endoscopic ultrasound examination</td>
</tr>
<tr>
<td>45342</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)</td>
</tr>
<tr>
<td>45345</td>
<td>Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with transendoscopic stent placement (includes predilation)</td>
</tr>
</tbody>
</table>

Table 5: ICD-9 Procedure Codes for Identifying Sigmoidoscopies

<table>
<thead>
<tr>
<th>ICD-9 Procedure Code</th>
<th>ICD-9 Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45.24</td>
<td>Flexible sigmoidoscopy</td>
</tr>
</tbody>
</table>

Table 6: HCPCS Codes for Identifying Sigmoidoscopies

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>HCPCS Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0104</td>
<td>Colorectal cancer screening; flexible sigmoidoscopy</td>
</tr>
</tbody>
</table>

Table 7: CPT Procedure Codes for Identifying Stool Tests

<table>
<thead>
<tr>
<th>CPT Procedure Code</th>
<th>CPT Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82270</td>
<td>Blood, occult, by peroxidase activity (e.g. guaiac), qualitative, feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e. patient was provided 3 cards or single triple card for consecutive collection)</td>
</tr>
<tr>
<td>82274</td>
<td>Blood, occult, by peroxidase activity (e.g. guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening</td>
</tr>
</tbody>
</table>

Table 8: HCPCS Codes for Identifying Stool Tests

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>HCPCS Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0328</td>
<td>Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous</td>
</tr>
</tbody>
</table>

Table 9: LOINC Codes for identifying stool tests

<table>
<thead>
<tr>
<th>LOINC Code</th>
<th>LOINC Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2335-8</td>
<td>Hemoglobin.gastrointestinal</td>
</tr>
<tr>
<td>12503-9</td>
<td>Hemoglobin.gastrointestinal^4th specimen</td>
</tr>
<tr>
<td>12504-7</td>
<td>Hemoglobin.gastrointestinal^5th specimen</td>
</tr>
<tr>
<td>14563-1</td>
<td>Hemoglobin.gastrointestinal^1st specimen</td>
</tr>
</tbody>
</table>
Table 10: All Colorectal Cancer Screening Codes

<table>
<thead>
<tr>
<th>CPT Procedure Codes</th>
<th>ICD-9 Procedure Codes</th>
<th>HCPCS Codes</th>
<th>LOINC Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392, 82270, 82274</td>
<td>45.22, 45.23, 45.25, 45.42, 45.43</td>
<td>G0104, G0105, G0121, G0328</td>
<td>2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2</td>
</tr>
</tbody>
</table>

Codes Used to Identify Patients who Meet Exclusion Criteria

Table 11: CPT Procedure Codes for Identifying Total Colectomy

<table>
<thead>
<tr>
<th>CPT Procedure Code</th>
<th>CPT Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44150</td>
<td>Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy</td>
</tr>
<tr>
<td>44151</td>
<td>Colectomy, total, abdominal, without proctectomy; with continent ileostomy</td>
</tr>
<tr>
<td>44152</td>
<td>Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed</td>
</tr>
<tr>
<td>44153</td>
<td>Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir [S or J], includes loop ileostomy, and rectal mucosectomy, when performed</td>
</tr>
<tr>
<td>44155</td>
<td>Colectomy, total, abdominal, with proctectomy; with ileostomy</td>
</tr>
<tr>
<td>44156</td>
<td>Colectomy, total, abdominal, with proctectomy; with continent ileostomy</td>
</tr>
<tr>
<td>44157</td>
<td>Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed</td>
</tr>
<tr>
<td>44158</td>
<td>Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed</td>
</tr>
</tbody>
</table>
Colorectal Cancer Screening
2013 Summary Data Submission
Measure Specifications

<table>
<thead>
<tr>
<th>CPT Procedure Code</th>
<th>CPT Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44210</td>
<td>Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy</td>
</tr>
<tr>
<td>44211</td>
<td>Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed</td>
</tr>
<tr>
<td>44212</td>
<td>Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy</td>
</tr>
</tbody>
</table>

Table 12: ICD-9 Procedure Codes for Identifying Total Colectomy

<table>
<thead>
<tr>
<th>ICD-9 Procedure Code</th>
<th>ICD-9 Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45.81</td>
<td>Total intra-abdominal colectomy</td>
</tr>
<tr>
<td>45.82</td>
<td>Open total intra-abdominal colectomy</td>
</tr>
<tr>
<td>45.83</td>
<td>Other and unspecified total intra-abdominal colectomy</td>
</tr>
</tbody>
</table>

Table 13: ICD-9 Diagnosis Codes for Identifying Colorectal Cancer

<table>
<thead>
<tr>
<th>ICD-9 Diagnosis Code</th>
<th>ICD-9 Diagnosis Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>153.0</td>
<td>Malignant neoplasm of the colon, hepatic flexure</td>
</tr>
<tr>
<td>153.1</td>
<td>Malignant neoplasm of the colon, transverse flexure</td>
</tr>
<tr>
<td>153.2</td>
<td>Malignant neoplasm of the colon, descending colon</td>
</tr>
<tr>
<td>153.3</td>
<td>Malignant neoplasm of the colon, sigmoid colon</td>
</tr>
<tr>
<td>153.4</td>
<td>Malignant neoplasm of the colon, cecum</td>
</tr>
<tr>
<td>153.5</td>
<td>Malignant neoplasm of the colon, appendix</td>
</tr>
<tr>
<td>153.6</td>
<td>Malignant neoplasm of the colon, ascending colon</td>
</tr>
<tr>
<td>153.7</td>
<td>Malignant neoplasm of the colon, splenic flexure</td>
</tr>
<tr>
<td>153.8</td>
<td>Malignant neoplasm of the colon, other specified site of large intestine</td>
</tr>
<tr>
<td>153.9</td>
<td>Malignant neoplasm of the colon, unspecified</td>
</tr>
<tr>
<td>154.0</td>
<td>Malignant neoplasm of rectum, rectosigmoid junction, and anus; Rectosigmoid junction</td>
</tr>
<tr>
<td>154.1</td>
<td>Malignant neoplasm of rectum, rectosigmoid junction, and anus; Rectum</td>
</tr>
<tr>
<td>197.5</td>
<td>Secondary malignant neoplasm of respiratory and digestive systems; Large intestine and rectum</td>
</tr>
<tr>
<td>V10.05</td>
<td>Personal history of malignant neoplasm; Gastrointestinal tract; Large intestine</td>
</tr>
</tbody>
</table>

Table 14: HCPCS Codes for Identifying Colorectal Cancer

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>HCPCS Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0213</td>
<td>Pet imaging whole body; diagnosis; colorectal</td>
</tr>
<tr>
<td>G0214</td>
<td>Pet imaging whole body; initial staging; colorectal</td>
</tr>
<tr>
<td>G0215</td>
<td>Pet imaging whole body; restaging; colorectal cancer (replaces g0163)</td>
</tr>
<tr>
<td>G0231</td>
<td>Pet, whole body, for recurrence of colorectal or colorectal metastatic cancer; gamma cameras only</td>
</tr>
</tbody>
</table>
Table 15: CPT Procedure Codes for Identifying CT Colonographies

<table>
<thead>
<tr>
<th>CPT Procedure Code</th>
<th>CPT Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>74261</td>
<td>Computed tomographic (CT) colonography, diagnostic, including image post processing; without contrast material</td>
</tr>
<tr>
<td>74262</td>
<td>Computed tomographic (CT) colonography, diagnostic, including image post processing; with contrast material(s) including non-contrast images, if performed</td>
</tr>
<tr>
<td>74263</td>
<td>Computed tomographic (CT) colonography, screening, including image post processing</td>
</tr>
<tr>
<td>0066T</td>
<td>Computed tomographic colonography (i.e., virtual colonoscopy); screening</td>
</tr>
<tr>
<td>0067T</td>
<td>Computed tomographic colonography (i.e., virtual colonoscopy); diagnostic</td>
</tr>
</tbody>
</table>

Table 16: All Exclusion Codes

<table>
<thead>
<tr>
<th>CPT Procedure Codes</th>
<th>ICD-9 Diagnosis Codes</th>
<th>ICD-9 Procedure Codes</th>
<th>HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>44150, 44151, 44155, 44156, 44157, 44158, 44210, 44211, 44212, 74261, 74262, 74263, 0066T, 0067T</td>
<td>153.X, 154.0, 154.1, 197.5, V10.05</td>
<td>45.81, 45.82, 45.83</td>
<td>G0213</td>
</tr>
</tbody>
</table>
Colorectal Cancer Screening
2013 Summary Data Submission
Measure Flow Charts

Measure Flow Charts

Is the patient’s DOB between 06/30/1937 and 06/30/1962?

Yes

Has the patient been seen by an eligible provider in an eligible specialty face-to-face at least two times between 07/01/2011 to 06/30/2013 and at least once between 07/01/2012 to 06/30/2013?

No

PATIENT NOT INCLUDED IN MEASURE

Yes

Did the patient have a colonoscopy between the dates of 07/10/2003 to 06/30/2013?

No

Did the patient have a sigmoidoscopy between the dates of 07/01/2008 to 06/30/2013?

Yes

PATIENT INCLUDED IN NUMERATOR

No

Did the patient have 1 or more stool tests returned?

Yes

Is the stool blood test a FIT?

No

Is the stool blood test a gFOBT?

Yes

Did the patient have 3 or more stool tests returned?

No

PATIENT NOT INCLUDED IN NUMERATOR

No

2013 Colorectal Cancer Screening Measure Flow Chart
Please see the Data Elements Table on Pages 16-19 for more detailed information about each colorectal cancer screening test.

PATIENT INCLUDED IN DENOMINATOR

No

PATIENT NOT INCLUDED IN MEASURE

Yes

Did the patient have a stool blood test between the dates of 07/01/2012 to 06/30/2013?

No

Is the stool blood test a FIT?

Yes

Did the patient have 3 or more stool tests returned?
Colorectal Cancer Screening
2013 Summary Data Submission
(07/01/2012 to 06/30/2013 Dates of Service)

Data Elements and Field Specifications

Please note: Data elements and field specifications listed in this section are included to assist in your clinic’s data collection and are not required to be included in your clinic’s Summary Data Submission for the Minnesota Statewide Quality Reporting and Measurement System.
Colorectal Cancer Screening
2013 Summary Data Submission
Data Elements and Field Specifications

Use the Colorectal Total Pop tab in the CRC 2013 SDS Spreadsheet to collect the following data elements for this measure.

<table>
<thead>
<tr>
<th>Column</th>
<th>Field Name</th>
<th>Notes</th>
<th>Excel Format</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Clinic ID</td>
<td>Enter the <strong>MNCM Clinic ID</strong> for every patient/row submitted. MNCM assigns the clinic ID at the time of registration. Clinic IDs are listed in the MNCM Data Portal. Use the <strong>MNCM ID</strong> listed in the portal. Do NOT use the Medical Group ID. <strong>Quality Check:</strong> Verify all IDs match the MNCM ID in the portal. Verify that each cell has data (no cell should be blank).</td>
<td>Text</td>
<td>9999</td>
</tr>
<tr>
<td>B</td>
<td>Patient ID</td>
<td>Enter a unique patient ID that will identify each patient. <strong>Quality Check:</strong> Verify patients were not duplicated. If patient is duplicated, determine which clinic you will attribute patient to. If submitting a sample population, you will need to replace the deleted record with the next sampled patient. Verify that each cell has data (no cell should be blank).</td>
<td>Text</td>
<td>200</td>
</tr>
<tr>
<td>C</td>
<td>Patient’s Date of Birth</td>
<td>Enter the patient’s date of birth. Patient must be ages 51-75 at the start of the measurement year with a birth date from 07/01/1937 to 06/30/1962. <strong>Quality Check:</strong> Verify each date of birth is within the accepted range. Verify that each cell has data (no cell should be blank).</td>
<td>Date</td>
<td>05/08/1955</td>
</tr>
<tr>
<td>D</td>
<td>Insurance Product Name</td>
<td>Enter the name of the patient’s insurance product name. This information is used to identify Primary Payer Type in Column E. If the patient does NOT have insurance, enter “Uninsured/Self-Pay.” <strong>Quality Check:</strong> Verify each cell has data (no cell should be blank).</td>
<td>Text</td>
<td>BlueCross BlueShield</td>
</tr>
</tbody>
</table>
## Colorectal Cancer Screening
### 2013 Summary Data Submission
#### Data Elements and Field Specifications

<table>
<thead>
<tr>
<th>Primary Payer Type</th>
<th>Enter the code for the primary payer type category (use the insurance data in previous fields to identify primary payer type):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 = Commercial/private</td>
</tr>
<tr>
<td></td>
<td>7 = Minnesota Health Care Programs</td>
</tr>
<tr>
<td></td>
<td>5 = Medicare</td>
</tr>
<tr>
<td></td>
<td>8 = Uninsured/self-pay</td>
</tr>
</tbody>
</table>

*If the product name is MSHO (Minnesota Senior Health Options) OR Medicaid fee-for-service, enter the code for MN Health Care Programs (7).*

**Quality Check:** Verify that each cell has an accepted code (1, 7, 5 or 8).

<table>
<thead>
<tr>
<th>Date of colonoscopy</th>
<th>Enter the date that corresponds to the patient’s most recent colonoscopy. Leave BLANK if the patient does not have a colonoscopy documented.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>Date of colonoscopy within the reporting period or previous nine years (07/01/2003 to 06/30/2013)</td>
</tr>
</tbody>
</table>

- Acceptable documentation to correspond with the date of the procedure can come from claims codes, colonoscopy report, or patient reported procedure date.
- Enter the date of the most recent colonoscopy, even if the procedure occurred prior to 07/01/2003 for auditing purposes.
- The date the procedure was performed is required. The result or report is not required if the screening exam is a part of the “medical history.”
- Date of colonoscopy order alone does not count – if the date of the exam is not part of the medical history the result or report must be produced on audit.
- If the exact date is not documented, a month and year only are acceptable on audit (example June of 2004 could be documented as 06/01/2004).

**Quality Check:** Verify that there are no dates after 06/30/2013 if data is entered into the cell.

<table>
<thead>
<tr>
<th>Date of sigmoidoscopy</th>
<th>Enter the date that corresponds to the patient’s procedure date of the sigmoidoscopy. Leave BLANK if patient does not have a sigmoidoscopy documented.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>Date of sigmoidoscopy within the</td>
</tr>
</tbody>
</table>

- Acceptable documentation to correspond with the date of the procedure can come from claims codes, sigmoidoscopy report, or patient reported procedure date.
### Colorectal Cancer Screening
#### 2013 Summary Data Submission

**Data Elements and Field Specifications**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
</table>
| Reporting period or previous four years (07/01/2008 to 06/30/2013) | - Enter the date of the most recent sigmoidoscopy, even if the procedure occurred prior to 07/01/2006 for auditing purposes.  
- The date the procedure was performed is required, the result or report is not required if the screening exam is a part of the “medical history.”  
- Date of sigmoidoscopy order alone does not count – if the date of the exam is not part of the medical history the result or report must be produced on audit.  
- If the exact date is not documented, a month and year only are acceptable on audit (example October of 2009 could be documented as 10/01/2009). |

**Quality Check:** Verify that there are no dates after 06/30/2013 if data is entered into the cell.

| H | Date of stool blood test order | Enter the date that corresponds to the order of the most recent stool test for the purpose of detecting colorectal cancer. Leave BLANK if patient does not have an order for stool blood tests documented.  
- Fecal occult blood test (FOBT) during the measurement year. This can be either a guaiac (gFOBT) or fecal immunochemical test (FIT).  
- The date the result/samples were returned is acceptable if it occurs within the reporting period. The date the result was “recorded” or “entered into the medical record” would not acceptable.  
- Enter the date of the most recent order for a stool blood test, even if the procedure occurred prior to 07/01/2011 for auditing purposes. |

**Quality Check:** Verify that there are no dates after 06/30/2013 if data is entered into the cell.

| I | Stool test type ordered | If the patient has a stool test ordered as noted in Column H (Date of stool blood test order), enter the name of the stool test ordered equal to one of the text strings below:  
- gFOBT = Guaiac Fecal Occult Blood Test  
- FIT = Fecal Immunochemical Test  

**Quality Check:** Verify text is entered if Column H is populated. If Column H is BLANK, verify this cell is also blank. |

| Date (mm/dd/yyyy) | 07/22/2012 |
| Text string | gFOBT |
Colorectal Cancer Screening  
2013 Summary Data Submission  
Data Elements and Field Specifications

| J | Number of stool tests returned | If the patient has a stool test ordered as noted in the “date of stool blood test order” column, enter the number of tests returned by the patient. Quality Check: Verify text is entered if Column H and Column I are populated. If Column H and Column I are BLANK, verify this cell is also blank. | Number | 3 |

- Number of stool tests returned:
  - gFOBT = 3 or more samples were returned
  - FIT = 1 or more samples were returned
Colorectal Cancer Screening
2013 Summary Data Submission
(07/01/2012 to 06/30/2013 Dates of Service)

Data Submission Instructions
About Summary Data Submission

The goal of data submission is to collect aggregate or summary data from physician clinics on specific health care conditions and publicly report comparable rates of health care quality at the physician clinic site level. All medical groups follow the same instructions for population identification and data collection. MNCM certifies methodologies prior to data collection. Then, each medical group submits summary data counts to the Minnesota Department of Health (MDH) for the Minnesota Statewide Quality Reporting and Measurement System via MNCM’s secure, online data portal. As an independent auditor, MNCM may validate the data for accuracy. The data will be publicly reported by MDH.

Purpose and Function of this Guide

This guide is intended to be a comprehensive instruction for the Summary Data Submission (SDS) process. Please contact MNCM with any questions or feedback by email: support@mncm.org.

Important Information for 2013 Reporting

Reporting requirements for the Minnesota Statewide Quality Reporting and Measurement System: By completing the registration process in the MNCM Data Portal and by completing the Summary Data Submission (SDS) process outlined in this guide, a physician clinic will fulfill the state requirements for reporting on this measure.

Total population submission for physician clinics using an electronic medical record: Physician clinics with electronic medical records (EMRs) in place for the prior full measurement period (07/01/2011 to 06/30/2012) are required to submit data on their full patient population. Physician clinics without EMRs in place for the prior full measurement period are encouraged to submit data using their full patient population for each measure, but may use a random sampling methodology (please see page 28-29 for more information).

Participation Requirements

Physician clinics are required to participate in the clinical quality data submission process and to do the following:

- Follow the timeline outlined in this guide
- Agree to MNCM’s Site Terms of Use Agreement (sign electronically on the MNCM Data Portal)
- Submit summary data counts for each physician clinic location rather than at a medical group level
- Submit data in required format (summary data counts)
- Participate in the data validation processes as required by the Minnesota Department of Health

Confidentiality and Patient Personal Health Information (PHI)

Because medical groups will maintain the detailed patient information and will only submit summary data counts for the clinical quality measures, no personal health information (PHI) is transferred during the summary data submission (SDS) process.
Overview of the Process and Timeline

<table>
<thead>
<tr>
<th>Process Step</th>
<th>Helpful Dates to Remember</th>
</tr>
</thead>
</table>
| Registration | • Registration occurs annually during the fall (communication is sent to all primary portal data contacts when portal is open for registration).  
• Contact MNCM at support@mncm.org if your clinic did not register. |
| Medical group registers clinics and providers on the MNCM Data Portal and electronically signs the Site Terms of Use Agreement and Business Associate Agreement.  
• NOTE: If you have already registered for 2013, you do not need to register again or complete separate agreements for submission of the Colorectal Cancer Screening measure. If you have not registered, you must do so before you can submit data. |
| Population Identification (Denominator) | • Denominator certification submission can begin after registration.  
• Recommended deadline: prior to November 30, 2013.  
• MNCM responds within 2-3 business days. |
| Medical group submits a document outlining the method for identifying the patient population (denominator) to the MNCM Data Portal. MNCM reviews and approves the denominator.  
• IMPORTANT: MNCM must certify the denominator prior to sampling and data collection to ensure that the correct patient population is being pulled. |
| Data Collection and Submission | • MNCM Data Portal closes for SDS Data Submission in December 2013. |
| Medical group collects clinical data and calculates summary counts that are entered in the MNCM Data Portal. Data collection begins after the billing cycle is complete for the measurement period. |
| Resources: Download from MNCM Data Portal [https://data.mncm.org](https://data.mncm.org) under RESOURCES tab:  
• SDS Data Collection Guide for Colorectal Cancer Screening  
• Data Collection Form for Colorectal Cancer Screening (optional)  
• CRC 2013 SDS Data Spreadsheet for Colorectal Cancer Screening Summary Data Submission |
| Respond to Data Validation Requests | After the summary data is successfully entered in the MNCM Data Portal, MNCM may contact the clinic with a data validation request. |
| MNCM may contact physician clinics to conduct data validation activities. |
| Data Results | Late 2013. |
| After the successful submission of the clinical data, the results will be publicly reported. |

**Thank you** for your participation in the Minnesota Statewide Quality Reporting and Measurement System.
Step 1: Registration on the MNCM Data Portal and Preparations

Registration must be completed once annually. Please refer to separate registration instructions for step-by-step instructions for this process. A downloadable instructional guide is available on the MNCM Data Portal. Please see Appendix B for more information for more detailed information regarding the clinic site definition and types of clinics.

Other data submission preparations:

- Save the MNCM Web sites in your “Favorites” internet folder for future reference.
  - MNCM Data Portal: [https://data.mncm.org/login](https://data.mncm.org/login)
  - MNCM Web Site: [www.mncm.org](http://www.mncm.org)
  - MN HealthScores: [www.mnhealthscores.org](http://www.mnhealthscores.org)
- Create a folder in your network drive dedicated to all data submission documents.
  - Save all spreadsheets, forms and data submission materials in the dedicated folder.
- Name versions of documents clearly so you are using the most recent files.
- Log in to the MNCM Data Portal at [https://data.mncm.org/login](https://data.mncm.org/login). In the RESOURCES tab of the data portal, you are able to access the following items:
  - Summary Data Submission Resources. Download the following
    - Colorectal Cancer Screening 2013 Summary Data Submission Guide
    - Colorectal Cancer Screening 2013 Denominator Certification Form
    - Colorectal Cancer Screening 2013 Data Collection Form
    - CRC 2013 SDS Spreadsheet Excel Template
Step 2: Identifying the Patient Population (Denominator)

Denominator Definition: The denominator is the bottom number in a fraction. In epidemiology, the denominator represents a population group at risk of a specific disease.

In this step, the total number of patients who are eligible for the measure are identified using a standard set of criteria. Please review the “Denominator” section noted in the Measure Specifications in this guide for the detailed criteria used to identify eligible patients for the denominator.

Certification of the Patient Population (Denominator Certification)

To help medical groups achieve accuracy and/or avoid inadvertently pulling the wrong patient population for the measure, MNCM will complete an upfront review of each medical group’s source code or methodology that is used to produce the patient population (denominator) to help identify potential errors. The denominator certification process is intended to help identify potential issues prior to data submission. However, the responsibility to submit an accurate denominator rests with the medical group. Please contact support@mncm.org with any specific questions.

PLEASE NOTE: Denominator certification may also include a comprehensive review by MNCM of the process steps used to identify the denominator, including the final list of patients. Please save all original queries, documents, spreadsheets and process steps that are used to identify the patient population. MNCM may ask to review this information.

Denominator Template Form

This template is provided to ensure all medical groups are using the same set of criteria to identify patients for the denominator. Medical groups are asked to complete this form and submit it to the MNCM Data Portal. Source code or “screen shots” are also helpful in MNCM’s review of the denominator.

2. Go to the RESOURCES tab and select Colorectal Cancer Screening Resources from the drop-down menu. Download the Denominator Template form.
3. Complete the form and save the form on your network directory.
4. Login to the MNCM Data Portal and click on Denominator Certification under the Colorectal Cancer Screening – Data Submission - 2013 Report (07/01/2012-06/30/2013 DOS) section. Follow the instructions to upload the form to the data portal.
5. MNCM will review the method and respond within 2-3 business days. MNCM will either (1) contact the medical group if more clarification is needed, in which case the medical group will need to make the necessary revisions and re-upload the form, or (2) certify the method in the MNCM Data Portal. An automatic e-mail will notify the medical group that the method is certified.
Details for the Denominator Methodology

The denominator template form provides a template for you to address all the elements that MN Community Measurement needs to certify your denominator. In your denominator form, MNCM should be able to identify:

- Birth date ranges used
- ICD-9-CM codes included
- Visit date range and visit count details that ensures established patient criteria were followed
- Description of how patients will be attributed (assigned) to one provider and one clinic
- Board certified specialties offered by the medical group that ensures the appropriate specialties for each measure were included
- Whether exclusions will be taken and how exclusions will be handled
  - Clinics using an electronic medical record may list which allowable exclusions will be filtered through the query process
  - Clinics that will manually abstract data may describe that exclusions will be identified and documented during record review
- Whether total population or a sample of the patient population will be used to calculate summary data counts; if a sample, the process for generating a sample
- “Inactive” patients: Patients designated as “inactive” in a practice management system, billing system or electronic medical record must be included in the patient population if they meet the criteria.
- Source code or “screen shots” may be included

Do NOT include patient lists or PHI (personal health information) as part of your denominator document. Please use the document template for Colorectal Cancer Screening (Word document) and paste your query source code at the end of the document.

Do NOT start collecting data until your clinic’s denominator has been certified.

Once you have submitted your documents for denominator certification, we will review them and notify you via email when your process has been certified. It is our aim to complete all certifications within two business days. If you have not received a notification within five business days, contact support@mncm.org.

### Patient attribution:

A patient is attributed to one clinic and one provider that are considered to be responsible for managing the patient’s care. Please use the following attribution methods in order:

1. First, attribute the patient to the clinic and provider that are assigned to the patient and are responsible for the patient’s care. If the patient does not have an assigned clinic or provider, then
2. Attribute the patient to the clinic and provider that saw the patient most often in the measurement period. If more than one provider saw the patient equally, then
3. Attribute the patient to the clinic and provider that saw the patient most recently in the measurement period.

If a provider has left the clinic, you may attribute the patient to the provider who has left or to a new provider now managing the patient’s care.
System Query: Helpful data elements that can be included in the system query

- **Clinic or facility:** This information must be substituted with the Clinic ID as noted in the MNCM Data
- **Patient name and ID number**
- **Patient Date of Birth (DOB)**
- **Insurance information:** This information can be used to determine primary payer type (Commercial/Private, Minnesota Health Care Programs, Medicare, Uninsured/Self-pay).
- **Date of last visit in the measurement period:** This is not necessary but may be helpful when abstracting data.

If a medical group opened or acquired a new clinic in the last year, the new clinic must register and submit data with the medical group. If the new clinic uses a different practice management system, billing system or EMR, they would identify patients and collect the data separately from the other clinics in the medical group, but would include their data in the same file that the medical group uses to calculate SDS counts to submit to MNCM (the identifier is the Clinic ID).

For medical groups that implemented a new practice management system or EMR in the last two years:
Please consider how to generate the patient population using both systems. Two queries or patient lists may be necessary. The lists should then be combined and a common identifier(s) selected to de-duplicate the list. Please contact support@mncm.org with any questions.

**Finalizing the patient population list:**

1. **Sort the list by the clinic site (where the patient is attributed).**
2. **De-duplicate the list and include only one record for each patient.** If a patient is listed more than one time within a clinic or within the entire medical group, determine which provider or clinic the patient will be attributed to and delete the other patient record/row.
   
   Tip: The Excel PivotTable function can show counts of patients. Use the patient medical record number, account number or other unique ID as the common identifier.
3. **Evaluate the number of patients in the population:** Is the total number of patients in the population similar to last year? If the totals are significantly different, does the difference make sense? Maybe a clinic opened/closed, or maybe a clinic’s overall patient population increased/decreased this year, etc. Does a correction in the methodology or query need to be made?

**Allowable Exclusions**

Allowable exclusions are kept to a minimum and are supported by evidence. The evidence must show frequency of occurrence in which the results would be distorted without the exclusion or is clinically appropriate. Please see the “Allowable Exclusions” noted in the Measure Specifications on page 6 and Tables 11 to 16 on pages 11 to 13 for a complete list of allowable exclusions.
If a patient meets the established patient criteria for the population and none of the allowable exclusions apply, the patient must be included.

Tracking excluded patients found during data collection:

- Track excluded patients found during data collection for validation purposes:
  - **Exclusions Tab**: A separate tab titled CRC Exclusions in the CRC 2013 SDS Data Spreadsheet template is used for tracking excluded patients.
  - If a sample of patients will be used and a patient that meets one of the exclusion reasons above is found, document this reason on the original patient list or data submission template, and enter this patient in the Exclusions Tab.
  - If the total population will be used using an EMR extraction of data, it is okay to maintain a different Excel file of excluded patients that are removed from the population. Using the CRC Exclusions Tab in the CRC 2013 SDS Data Spreadsheet template is not necessary, although the exclusion reason for each patient must be clear.
- Do NOT enter patients who did not meet the initial established patient criteria (e.g., not ages 51-75, did not meet the visit criteria, etc.).

Visits: Helpful information for identifying the patient population

For the purposes of determining if a patient is established to a practice, medical groups will count the number of face-to-face visits using the criteria described in the Measure Specifications in this guide. Medical groups may have different ways of defining or classifying visit types within a practice, but the intent is to count visits where there is face-to-face evaluation of the patient by a MD, DO, PA or NP. Face-to-face visits include the following visit types: office visit, physical exam, annual visits, and pre-op visits.

If the clinic offers after-hours primary care, these patients must be included. Do NOT include hospital visits. Clinic lab-only visits or nurse blood pressure checks are not included in the visit count.

Evaluation & Management CPT Codes (optional)

The following list of codes may be helpful in determining what types of visits to include for identifying the patient population (denominator). E & M codes do not need to be used when querying a practice management system to determine visit counts; however, they have been included here to help further define what is meant by a “face-to-face” visit with a provider. Please refer to a CPT coding manual for more details.

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E &amp; M Codes</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Codes</td>
<td>99201 – 99205, 99211 – 99215</td>
</tr>
<tr>
<td>Office Consultation</td>
<td>99386 – 99387, 99396 – 99397</td>
</tr>
<tr>
<td>Individual Counseling</td>
<td>99241 – 99245</td>
</tr>
<tr>
<td>Group Counseling</td>
<td>99401 – 99404</td>
</tr>
<tr>
<td>Other Preventive Medicine Services</td>
<td>99411 – 99412</td>
</tr>
<tr>
<td>Unlisted E &amp; M Codes</td>
<td>99420, 99429</td>
</tr>
<tr>
<td></td>
<td>99499</td>
</tr>
</tbody>
</table>
Total Population Submission

Physician clinics with electronic medical records in place for the prior full measurement period (07/01/2011 to 06/30/2012) are required to submit data on their full patient population. Physician clinics without electronic medical records in place for the prior full measurement period are encouraged to submit data using their full patient population for each measure, but may use a random sampling methodology. Using the total population to calculate the rates creates a higher likelihood that the rate accurately reflects the physician clinic’s performance.

Sample Submission

Using a sample is also an option (e.g., for clinics that use paper records or for clinics that do not have a fully implemented EMR). Below are the requirements for using a sample to calculate the summary data counts:

- Each clinic must use a sample.
- If a clinic has fewer than 60 patients in the population for the measure, use ALL patients (e.g., if a total of 59 patients are in the population for the measure, use all 59 patients).
- If a clinic has 60 or more patients, first consider using all patients, otherwise you may use a sample. The minimum required sample is 60 patients per clinic site (e.g., if there are 79 eligible patients in the population, first consider using all 79 patients, otherwise use a sample of at least 60).

Random Sample Selection Methods

METHOD 1: Excel Random Number Generator Sample Selection:

Enter all the patient data into the CRC 2013 SDS Data Spreadsheet Template on the Colorectal Total Pop tab. Complete the following steps using the data entered on the Colorectal Total Pop tab. For patient lists generated in Excel, use the “RAND” function to assign a random number to each record (please also see Microsoft Excel Help, topic RAND for more information):

1. Enter all the patient data into the CRC Total Pop tab.
2. Insert a blank column on the leftmost side of the spreadsheet and label new column “RAND”
3. Place cursor in the first blank cell (A2) and type =RAND()
4. Press enter (a number like 0.793958 will appear)
5. Place the cursor back into this cell; resting over the corner to have the pointer change to a black cross, double click or drag the formula down to the last row/patient
6. Highlight the whole column and click Edit, Copy, Paste Special = Values to freeze the random number (otherwise it will change with every click in the spreadsheet)
7. Sort entire patient population by this new random number
8. Work down the list row by row, starting with row 1 until the number of records in the sample is met for submission (at least 60 patients per clinic, per measure)
9. Copy and paste the selected patient data to the Colorectal Sample Pop tab in the CRC 2013 SDS Data Spreadsheet.
10. If a patient meets one of the accepted exclusions, note this in the exclusions spreadsheet and keep working down the list. Use oversample records following the last record/row of the original sample.
example, if 60 records will be used and exclusions were found in the first 60 records/rows, use patients from rows 61, 62, and so forth to replace the excluded records.

METHOD 2: Paper List Sample Selection:
For paper-generated lists, complete the following steps:

1. Start with a list that has patients sorted by some unique patient related variable.
   a. Identifying number like a medical record number [MRN] or chart number is ideal.
   b. Sorting alphabetically is the least desirable in terms of randomness; however, this may be used when there is no other alternative.
2. Select every Nth patient for the number of patients that will be reported.
   a. N should equal the clinic site’s total population divided by the number of patients that will be used (if needed, round down to the nearest whole number). Highlight or mark every Nth patient on the list. This is the sample.
   b. Example: If a clinic site has 600 eligible patients and 60 patients will be used, divide 600/60 = 10. Select every 10th patient on the list.
3. Enter the patient data into the Colorectal Sample Population tab in the CRC 2013 SDS Data Spreadsheet.
4. If a patient meets one of the accepted exclusions, note this in the data collection form and exclusions spreadsheet and select the very next patient on the list (just below the excluded patient).

Missing records: If a record in the sample is not available or “missing,” do NOT exclude this record. Either locate the record and complete the data collection, or include the record, but leave the data fields blank.
Step 3: Data Collection

Medical groups and physician clinics can collect clinical data from medical records by either: 1) extracting the data from an electronic medical record through a data query; or, 2) abstracting the data from the medical record (paper record or EMR). Data collection occurs after:

1. The clinic’s billing and medical record updates are complete for the measurement period,
2. The denominator method is certified by MNCM, and
3. The patient population is identified, and if applicable, a sample is selected according to the measure specifications and sampling instructions.

Tools for Data Collection and Data Entry

Data Collection Form

A data collection form was created for medical groups that manually collect data from an EMR or paper record. The necessary data elements are on the form. These forms can also be used to note where certain data elements were found in the medical record. Data collected on these forms must also be entered into the CRC 2013 SDS Data Spreadsheet. Please download these forms from the MNCM Data Portal under the RESOURCES tab, select Summary Data Submission from the drop-down menu.

Excel Template

The CRC 2013 SDS Data Spreadsheet template was created to ensure all necessary data elements are collected. This file contains all of the necessary fields as well as the correct column formatting according to the measure specifications. There are separate tabs for the detailed patient clinical data, exclusions and the final summary counts. Please download the CRC 2013 SDS Data Spreadsheet template from the MNCM Data Portal under the Resources tab, select Summary Data Submission from the drop-down menu.

Field Formatting in the Excel File:

Prior to entering data in the CRC 2013 SDS Data Spreadsheet template it is important that the field formats follow the measure specifications in this guide. Pay special attention to field formatting (e.g., dates look like dates, etc.).

Do NOT use “General” formatting in Excel. The Excel template provided on the MNCM Data Portal will provide the correct formatting.

Using Multiple Data Collectors and Inter-Rater Reliability (IRR)

Ideally, one data collector or data collection process is preferred because it ensures that the data is collected in one consistent way. If, however, more than one person will be abstracting data, we recommend conducting several sample audits with all abstractors for training purposes to improve IRR.

Internal training could include a review of the guide and data collection form and instructions for locating information in the clinic’s medical record. Also, refer to data collection errors made in previous submissions, make plans to improve the data collection process, and perform quality checks on the data. This ensures that the measurement specifications are interpreted consistently and that the data is collected in a uniform way.
Locating Data Elements in the Patient Record

The primary source of data is the clinic’s documentation in the medical record (e.g., flow sheets, progress notes, lab reports, etc.). Data collectors may also choose to review the outside correspondence in the clinic’s medical record that documents more recent data within the measurement period, but this is optional. If data is used from outside correspondence, please document this for the validation audit. Below are tips for locating data in the patient record.

Please follow the measure specifications for data collection.

Colonoscopy within the reporting period or previous nine years

- EMR documentation of the date procedure was performed from the progress note
- Documentation from an outside provider
- Copy of colonoscopy report as scanned into the EMR or paper medical chart
- Procedure documentation through the use of medical claims codes. Please see Tables 1-3 on pages 8-9 for a more detailed list:
  - Accepted colonoscopy CPT codes: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392
  - Accepted colonoscopy ICD-9 procedure codes: 45.22, 45.23, 45.25, 45.42, 45.43
  - Accepted colonoscopy HCPCS codes: G0105, G0121

Sigmoidoscopy within the reporting period or previous four years

- EMR documentation of the date procedure was performed from the progress note
- Documentation from an outside provider
- Copy of sigmoidoscopy report as scanned into the EMR or paper medical chart
- Procedure documentation through the use of medical claims codes. Please see Tables 4-6 on pages 9-10 for a more detailed list:
  - Accepted sigmoidoscopy CPT codes: 45330-45335, 45337-45342, 45345
  - Accepted sigmoidoscopy ICD-9 procedure codes: 45.24
  - Accepted sigmoidoscopy HCPCS codes: G0104

Fecal blood tests within the reporting period

- Date that one of the following acceptable stool tests was ordered as noted in the EMR: guaiac FOBT (gFOBT) and fecal immunochemical test (FIT).
- Procedure documentation through the use of medical claims codes. Please see Tables 7-9 on pages 10-11 for a more detailed list:
  - Accepted CPT codes: 82270, 82274
  - Accepted ICD-9 procedure codes: V76.51

Possible Validation Audit and Outside Correspondence in the Patient Record:

If the most recent data from the primary clinic’s medical record is used, validation will NOT do a more extensive review of outside correspondence.

Data Collection Tips:

- When manually collecting data using an EMR, highlight the row, column or cell that contains the data needed. This reduces the chance of looking at the wrong row, column or cell.
- Watch for TYPOS when entering data (number transpositions, etc.).
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- Accepted HCPCS codes: G0328, G0394
- Accepted LOINC codes: 12503-9, 12504-7, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3

Tracking Where Data is Located in the Patient Record

It is important to keep track of where data is located in the patient record. For example, if data is used from an outside specialist or provider note (that is within the primary clinic’s record), document the source on the data collection form or Excel spreadsheet.

If you are collecting data directly in the CRC 2013 SDS Data Spreadsheet template, create a “NOTES” column and enter the data source details in this column. After you have completed data collection, SAVE A COPY of the Excel file and remove the “NOTES” column in the file that will be used to calculate the summary data counts.

Patient Registries:

A patient registry is an important tool to help clinics track patient progress and to use for quality improvement purposes. However, MNCM cautions the use of a patient registry for identifying patients in the population or for the collection of clinical data. Many registries give a “snapshot” of patients at a given time and would therefore not include all patients for the MNCM measure according to established patient criteria or may not reflect the most recent clinical data (e.g., most recent screening exam). Registries that are programmed to update the patient population and clinical results on a continual basis (24/7) could possibly be used; however, please discuss this with MNCM.
Step 4: Data Quality Checks

MNCM recommends completing several internal quality checks of the data before calculating summary data counts. Performing quality checks in the CRC 2013 SDS Data Spreadsheet Template ensures that the data is accurate and able to be validated by a MNCM auditor if needed.

Excel’s AutoFilter

Use the Filter function in Excel to look for incorrect or missing data:

- Click inside any data cell and activate the AutoFilter by doing the following:
  - In Excel 2003, click the Data menu, point to Filter, and then click AutoFilter.
  - In Excel 2007 and 2010, click the Data tab and in the Sort & Filter area click Filter.
- The AutoFilter arrows now appear to the right of each column heading.
- Click on the drop-down boxes of any column and scan for key entry errors, “out-of-range” or missing data and determine if the data needs to be corrected (e.g., If a date for a LDL is entered as free text, “About three months ago,” the field would not be accepted.)
- To display all data again, click on the same drop-down box and select (All).
- Remove the Filter option by doing the following:
  - In Excel 2003, click Data, Filter, and AutoFilter again
  - In Excel 2007 and 2010, click the Filter option again in the Sort & Filter area

Example Quality Check: Verify that every stool blood test date is within the measurement period. First, turn on the Filter and in the “Date of stool blood test” column drop-down menu scroll and review all dates to ensure they are between 07/01/2012 to 06/30/2013.

Internal Audit of Clinical Data: Before calculating the summary data, you may wish to review a random sample of records (8-10) to see if the data matches what was collected from the patient record. If errors are found, make the corrections in the Excel file; however, also consider if the errors were isolated cases or indicative of a larger data collection problem. (Examples of a larger data collection problem: There are no patients with colonoscopy dates, and you are certain that colonoscopy dates are collected and should be in the data.)

Important Quality Checks (Excel File)

It is important to complete the following quality checks of the file before calculating summary data counts. Completing these checks can help avoid delays in the file submission and ensure that you have the most accurate data. Make any changes/additions in the Excel file before calculating summary data counts.
Step 5: Summary Data Submission (SDS)

Calculate Summary Data Counts

The next step is to calculate summary counts for each physician clinic by primary payer type (Commercial/Private, Minnesota Health Care Programs, Medicare, Uninsured/Self-pay). These counts will be submitted to MNCM. The CRC 2013 SDS Data Spreadsheet template that was used to enter detailed patient clinical data will be used to calculate the summary counts. A tab/worksheet in the CRC 2013 SDS Data Spreadsheet Template is included for entering the final summary counts by clinic.

Note: You will need the CRC 2013 SDS Data Spreadsheet template to complete this step. You can download this from the MNCM Data Portal under SDS Resources.

Before you start, it is important to finalize data collection, data entry and quality checks. Once this is complete, proceed with the following:

1. Combine all physician clinic files into one spreadsheet. The Clinic ID is the clinic identifier.
2. Check that any excluded patients are not included in the detailed patient clinical data. Remove any excluded patients and move these patients to the exclusions tab.
3. Sort the patient data by Clinic ID.

Now you may begin. Enter MNCM Clinic IDs for each clinic in Column A on the CRC Summary Tab. Excel’s Pivot Tables functions are used to complete the calculations (see more information about these functions in Excel’s Help).

If you are using your total population to calculate the counts, you will use the CRC Total Pop and the CRC Summary tabs for the following steps. If you are using a sample to calculate the counts, you will use the CRC Sample Pop and CRC Summary tabs for the following steps. Calculate the following summary counts from the CRC Total Pop or CRC Sample Pop tabs and enter these counts in the CRC Summary tab in the CRC 2013 SDS Data Spreadsheet template. Each count needs to be calculated for each clinic.

<table>
<thead>
<tr>
<th>Colorectal Cancer Screening Data Element</th>
<th>Suggested Calculation Method</th>
</tr>
</thead>
</table>
| Number of Patients That Meet Inclusion Criteria (Less Exclusions) | You must use the Colorectal Total Pop tab to create this summary count. Run a pivot table to create counts of patients. Use these variables:  
  - Row Labels  
    - Clinic ID  
  - Values  
    - Count of Patient ID  
Enter the values of Count of Patient ID on the CRC Summary tab in Column B for each clinic. |
# Colorectal Cancer Screening

## 2013 Summary Data Submission

### Data Submission Instructions

**Colorectal Cancer Screening**

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Suggested Calculation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Patients Submitting</strong></td>
<td>If you are submitting sample population, use the following method: You must use the Colorectal Sample Pop tab to create this summary count. Run a pivot table to create counts of patients.</td>
</tr>
<tr>
<td><strong>Sample Population Counts (Less Exclusions) by primary payer type</strong></td>
<td>You must use the Colorectal Total Pop or Colorectal Sample Pop tab to create this summary count. Run a pivot table to create counts of patients.</td>
</tr>
<tr>
<td><strong>Number of Patients Excluded</strong></td>
<td>You must use the CRC Exclusions tab to create this summary count. Run a pivot table to create counts of patients.</td>
</tr>
<tr>
<td>Data Element</td>
<td>Suggested Calculation Method</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------</td>
</tr>
</tbody>
</table>
| Number of Patients who were up to date with screening due to colonoscopy by primary payer type | You must use the Colorectal Total Pop or Colorectal Sample Pop tab to create this summary count. Run a pivot table to create counts of patients. **Use these variables:**  
  - Report Filter:  
    - Date of Colonoscopy: Select dates between 07/01/2003 and 06/30/2013  
  - Row labels:  
    - Clinic ID  
  - Column labels:  
    - Primary Payer Type  
  - Value Count:  
    - Patient ID  
  Enter the values of the Count of Patient IDs into the corresponding column on the CRC Summary tab in Columns M-P for each clinic. |
| Number of Patients who were up to date with screening due to sigmoidoscopy by primary payer type | You must use the Colorectal Total Pop or Colorectal Sample Pop tab to create this summary count. Run a pivot table to create counts of patients. **Use these variables:**  
  - Report Filter:  
    - Date of Sigmoidoscopy: Select dates between 07/01/2008 and 06/30/2013  
  - Row labels:  
    - Clinic ID  
  - Column labels:  
    - Primary Payer Type  
  - Value Count:  
    - Patient ID  
  Enter the values of the Count of Patient IDs into the corresponding column on the CRC Summary tab in Columns Q-T for each clinic. |
| Number of Patients who were up to date with screening due to FIT stool blood tests by primary payer type | You must use the Colorectal Total Pop or Colorectal Sample Pop tab to create this summary count. Run a pivot table to create counts of patients. **Use these variables:**  
  - Report Filter:  
    - Date of stool blood test order: Select dates between 07/01/2012 and 6/30/2013  
    - Stool test type ordered: FIT  
    - Number of stool tests returned for FIT: 1  
  - Row labels:  
    - Clinic ID |
### Data Submission Instructions

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Suggested Calculation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Column labels:</strong></td>
</tr>
<tr>
<td></td>
<td>o Primary Payer Type</td>
</tr>
<tr>
<td></td>
<td><strong>Value Count:</strong></td>
</tr>
<tr>
<td></td>
<td>o Patient ID</td>
</tr>
</tbody>
</table>

Enter the values of the Count of Patient IDs into the corresponding column on the CRC Summary tab in Columns U-X for each clinic.

#### Number of Patients who were up to date with screening due to gFOBT stool blood tests by primary payer type

You must use the Colorectal Total Pop or Colorectal Sample Pop tab to create this summary count. Run a pivot table to create counts of patients.

**Use these variables:**

- **Report Filter:**
  - Date of stool blood test order: Select dates between 07/01/2012 and 6/30/2013
  - Stool test type ordered: gFOBT
  - Number of stool tests returned: 3

- **Row labels:**
  - Clinic ID

- **Column labels:**
  - Primary Payer Type

- **Value Count:**
  - Patient ID

Enter the values of the Count of Patient IDs into the corresponding column on the CRC Summary tab in Columns Y-AB for each clinic.

#### Number of Patients who are Appropriately Screened by primary payer type

For the “Number of Patients who are Appropriately Screened: Commercial/Private” (Column AC), sum/add the numbers from the following columns on the CRC Summary tab and enter sum into Column AC.

- Number up to date with screening due to colonoscopy - COMMERCIAL/PRIVATE (Column M)
- Number up to date with screening due to sigmoidoscopy - COMMERCIAL/PRIVATE (Column Q)
- Number up to date with screening due to fecal immunochemical (FIT) stool blood tests - COMMERCIAL/PRIVATE (Column U)
- Number up to date with screening due to other stool blood tests (gFOBT) - COMMERCIAL/PRIVATE (Column Y)

For the “Number of Patients who are Appropriate Screened: MN Health Care Programs” (Column AD), sum/add the numbers from the following columns on the CRC Summary tab and enter sum into Column AD.

- Number up to date with screening due to colonoscopy - MN HEALTH CARE PROGRAMS (Column N)
- Number up to date with screening due to sigmoidoscopy - MN HEALTH CARE PROGRAMS (Column O)
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<table>
<thead>
<tr>
<th>Data Element</th>
<th>Suggested Calculation Method</th>
</tr>
</thead>
</table>
| PROGRAMS (Column R) | • Number up to date with screening due to fecal immunochemical (FIT) stool blood tests - MN HEALTH CARE PROGRAMS (Column V)  
• Number up to date with screening due to other stool blood tests (gFOBT) - MN HEALTH CARE PROGRAMS (Column Z) |

For the “Number of Patients who are Appropriate Screened: Medicare” (Column AE), sum/add the numbers from the following columns on CRC Summary the tab and enter sum into Column AE:

• Number up to date with screening due to colonoscopy – MEDICARE (Column O)  
• Number up to date with screening due to sigmoidoscopy – MEDICARE (Column S)  
• Number up to date with screening due to fecal immunochemical (FIT) stool blood tests - MEDICARE (Column W)  
• Number up to date with screening due to other stool blood tests (gFOBT) - MEDICARE (Column AA) |

For the “Number of Patients who are Appropriate Screened: Uninsured/self-pay” (Column AF) column, sum/add the numbers from the following columns on the CRC Summary tab and enter sum into Column AF:

• Number up to date with screening due to colonoscopy - UNINSURED/SELF-PAY (Column P)  
• Number up to date with screening due to sigmoidoscopy - UNINSURED/SELF-PAY (Column T)  
• Number up to date with screening due to fecal immunochemical (FIT) stool blood tests - UNINSURED/SELF-PAY (Column X)  
• Number up to date with screening due to other stool blood tests (gFOBT) - UNINSURED/SELF-PAY (Column AB) |

Enter the Summary Counts in to the MNCM Data Portal
The final step in the SDS process is to enter the summary counts from the CRC Summary Tab in the CRC 2013 SDS Data Spreadsheet template in to the MNCM Data Portal for each clinic.

Before you complete the steps below, log in to the MNCM data portal (https://data.mncm.org) and scroll to the Colorectal Cancer Screening measure.
NOTE: The following steps will be completed for each clinic.

Step 1 Enter Denominator: Enter the following information for each physician clinic row:

- **Method Used for Data Collection:** Select one of the methods from the drop-down box:
  - EMR: All data pulled via query
  - EMR: Some data looked up manually
  - EMR: All data looked up manually
  - Manual: Paper records only
  - Manual: EMR and paper record

- **Number of Patients That Meet Inclusion Criteria (Less Exclusions) - Column B:** Enter the number of patients who are eligible or met the inclusion criteria for the measure (based on diagnosis codes, age, visit criteria, etc.). Do NOT include patients who met an accepted exclusion (e.g., deceased, etc.). Including excluded patients in this count will decrease the final rate, so remember to subtract these patients from the total population.

- **Number of Patients Submitting - Column C:** This number will be the same as the number of eligible patients if you used your total population to calculate the summary data counts. If you used a sample population to calculate the summary data counts, this number will be the number of patients in your sample.

- **Not Reporting:** Check this box if the physician clinic is not required to report for this measure (e.g., pediatricians should not report this data).

Step 2 Review & Save: Verify the numbers entered and click Save and Continue, or click Back to Step 1 to re-enter.

Step 3: Product Lines: Sample Population Counts (Less Exclusions) - Columns D-G: Enter the number of patients whose data was used to create the summary data counts by payer type. Below are the corresponding columns on the appropriate tabs where the counts are located on the CRC Summary tab of the CRC 2013 SDS Data Spreadsheet:

- Commercial/Private (Column D)
- MN Health Care Program (Column E)
- Medicare (Column F)
- Uninsured/Self-Pay (Column G)

Step 4 Exclusions - Columns H-M: Enter a count for each exclusion type for each physician clinic. Click Save and Continue. Below are the columns that correspond to each exclusion count requested in the portal:

- In Hospice Care (Column H)
- Deceased (Column I)
- Patient has had a total colectomy (Column J)
- Patient has a previous diagnosis of colorectal cancer (Column K)
- Patient who had a CT Colonography (Column L)
**Step 5 Number Screened - Columns AC-AF**: Enter each physician clinic’s count of patients that met the target by primary payer type. Click *Save and Continue*. Below are the columns that correspond to each number screened requested in the portal:

- Commercial/Private (Column AC)
- MN Health Care Program (Column AD)
- Medicare (Column AE)
- Uninsured/Self-Pay (Column AF)

**Step 6 Review & Submit**: The portal will now calculate “Preliminary Rates” for each clinic. Please review this information and determine if the summary data is ready to submit to MNCM. Follow these steps:

1. **Edit button**: Click this button to edit any entries as necessary.
2. **Save as Draft button**: Click this button to save the entries. This does not submit the data to MNCM.
3. **Submit Data to MNCM button**: Click this button to submit final data to MNCM.

**Step 7 Done**: The summary data counts have been successfully submitted. MNCM will send an e-mail confirming that the data has been received.
Step 6: Required Documentation for Data Validation

Physician clinics must maintain documentation of the calculation of all applicable measures and maintain the record for two years. The documentation must include the detailed patient data, excluded patients and summary counts. The CRC 2013 SDS Data Spreadsheet template available from MNCM may be used for purposes of this documentation, as it includes all necessary data elements and field formatting.
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(07/01/2012 to 06/30/2013 Dates of Service)

Appendices
Appendix A

About MN Community Measurement and Measure Development

Mission and Vision of MN Community Measurement (MNCM)

The mission of MN Community Measurement is to accelerate the improvement of health by publicly reporting health care information. MN Community Measurement’s vision is to:

- Be the trusted source for performance measurement and public reporting of quality data across the spectrum of health care that
- Drive change towards more safe, effective, patient centered, timely, efficient, and equitable care
- Be a resource used by providers to improve care and patients to make better decisions
- Catalyze our community to work together on health care measurement to reduce administrative costs and maximize value.

About the Measure Development

Cancer of the colon and rectum is one of the most prevalent forms of cancer and one of the top three leading causes of cancer-related deaths for both men and women. The burden of colorectal cancer rests primarily in older adults. Over 75% of all deaths due to colorectal cancer occur in adults over the age of 65. At an aggregated level, about 6% of all Americans will be diagnosed with colorectal cancer at some point in their lives, but specific populations will be affected at different rates with men more likely to acquire than women, rural populations having higher incidence rates than urban, and American Indian populations seeing incidence rates far greater than other race/ethnicity groups.

The colorectal cancer screening measure currently reported by Minnesota Community Measurement comes from the NCQA’s HEDIS® colorectal cancer screening rate measure. The measure reports the percentage of patients at a medical group who have received colorectal cancer screening within a 12 month period by capturing the entire population ages 50 to 80 with screening tests either within the reporting period or in the medical history as dictated by the test type. Populations not represented by the current rate include patients who have Medicaid insurance and Medicare Fee-For-Service patients.

Unlike many cancers, colorectal cancer develops in a largely predictable progressive pattern where a small tissue growth in the large intestine can turn cancerous over a period of several months to several years. Screening for colorectal cancer to identify and remove these growths is believed to account for the biggest potential reduction in mortality rates. Preventing the incidence and mortality for colorectal cancer has been a key focus of several state and nationwide initiatives including Healthy People 2010, the Minnesota Cancer Alliance, and the American Cancer Society.

A direct data submission measure to identify colorectal cancer screening rates would have the following benefits: a) Can capture screening rates at a clinic site level; b) Can more appropriately capture the entire patient population in a clinic’s case mix by including Medicare Fee For Service and Medicaid patients; and c) Will potentially allow for a real impact on the burden and mortality of colorectal cancer due to early detection and prevention associated with increased screening.
The Colorectal Cancer Screening measure was developed using a technical advisory group of key stakeholders in the community that included family practice physicians, physicians who perform colonoscopies, health plan representatives, and others. After careful review of existing measures, clinical guidelines, and relevant medical research the technical advisory committee drafted the measure. The measure was released for public comment and approved by both the Reporting Advisory Committee and the Board of Directors at MN Community Measurement in 2009-2010 for implementation in 2010.
Appendix B

Clinic Site Definition

The Minnesota Statewide Quality Reporting and Measurement System and MN Community Measurement require that clinic locations be registered as follows:

1. Register each clinic location in the state of Minnesota where primary or specialty care ambulatory services are provided for a fee by one or more physicians. If the medical group has multiple clinic locations, register each location.

   A clinic site location is a building, separate space, or an entity with a street address. It should be a functional unit that is easily understood by patients/consumers. The goal of reporting by clinic site is to provide patients/consumers with information about the entity with which they are most familiar and to provide information to clinics that is actionable for quality improvement purposes.

2. For the purposes of reporting clinical quality data, most medical groups with multiple clinic locations will submit data for each individual location. However, medical groups whose clinics meet all of the following criteria may choose to submit data for all of the multiple clinic locations as a single entity:
   a. have common ownership, AND
   b. have a majority (more than half) of common clinical staff* working across the multiple locations (these clinical staff* must rotate between all of the clinic locations), AND
   c. the total clinical staff* across all locations is no greater than 20 full-time equivalent (FTE).

* Clinical staff is defined as the following provider types: physicians, advanced practice registered nurses, and physician assistants.

Please contact MNM if you are planning to submit data under one entity to ensure that your sites meet the eligibility criteria.

Clinics may not submit clinical quality data as one clinic location unless they meet all three criteria noted under #2 above. Below are examples to illustrate how clinics may or may not roll-up clinical quality data for reporting purposes:

- A system (medical group) of several clinic locations that has 100 clinical staff FTEs working across the multiple locations is required to submit data for each clinic location, including satellite and outreach sites, as long as the site has one or more physicians providing care.

- A system (medical group) of three clinic locations that has 15 clinical staff FTEs where all of the clinical staff rotate between all three clinic locations may roll-up and submit clinical quality data as a single entity.

- A system (medical group) of three clinic locations that has 15 clinical staff FTEs total where five of the clinical staff FTEs rotate between two clinic locations and 10 of the clinical staff FTEs do NOT rotate between clinic locations (e.g., the 10 FTEs see patients at one of the locations only) is required to report
clinical quality data for each clinic location and may **not** roll-up and submit clinical quality data as a single entity.

You may have questions about how the following types of clinics apply to your practice. If so, please contact MNCM (see contact information at the bottom of this page).

**Newly Opened/Acquired Clinics:** If a medical group opened or acquired a new clinic in the last year, the new clinic must register with the medical group and must submit data with the medical group. If the new clinic uses a different practice management system, billing system or EMR, the clinic would follow the same instructions and measure specifications to collect the data, and the medical group would include the new clinic’s data in the data submission to MNCM.

**Urgent Care Clinics:** Urgent care clinics must register and complete an annual Health Information Technology (HIT) survey and participate in surveying for the Patient Experience of Care measure. Urgent care clinics, however, are not required to submit data on clinical quality measures.

**Hospital-Based Outpatient Clinic Locations:** These are included in the physician clinic definition and must register and report required measures.

**Multi-Specialty Clinics:** A clinic site that has multiple specialties located in one building (one street address) has the option to register in a couple of ways. How clinics decide to register depends on how the clinic expects to report data on clinical measures. The registration options are:

1. Register and report data as one single clinic site (one clinic ID). **Please contact MNCM** (see contact information at the bottom of this page) if this is a change from the way your clinics were registered last year.
2. Register each individual specialty and the “main” clinic site in which the specialties are located (each specialty and the “main” clinic site will each have a unique clinic ID). Each specialty will report on applicable clinical measures, and the “main” clinic site will be used for the purposes of reporting on the HIT Survey and Patient Experience of Care Survey results. If you choose to register by specialty, you must:
   a. **Contact MNCM** (see contact information at the bottom of this page) before making any changes in the portal. If your questions are specific to the HIT Survey or the Patient Experience of Care Survey, please email surveysupport@mncm.org.
   b. Register all specialties even if there is currently not an applicable measure associated with the specialty.
**Example of a Multi-Specialty Clinic Registration:** “Northern Health Clinic” is located on one large clinic campus (one address) and offers a variety of specialties. This multi-specialty clinic has two options for registering and reporting clinical measures:

<table>
<thead>
<tr>
<th>Registration Option 1 (one unique clinic ID)</th>
<th>Registration Option 2 (unique clinic IDs for each specialty and the “main” clinic site)</th>
</tr>
</thead>
</table>
| Northern Health Clinic | Northern Health Clinic (main clinic)  
Northern Health Clinic – Family Medicine  
Northern Health Clinic – Internal Medicine  
Northern Health Clinic – Cardiology  
Northern Health Clinic – Endocrinology  
Northern Health Clinic – Pediatric Medicine  
Northern Health Clinic – Behavioral Health  
Northern Health Clinic – Dermatology  
Northern Health Clinic – Urgent Care  
Etc. |

*In this option, the main clinic site would complete the HIT Survey, participate in the Patient Experience of Care Survey, and submit data on applicable clinical measures.*

| | In this option, the main site would complete the HIT Survey and Patient Experience of Care Survey, but not clinical measures. The individual clinic specialties would report on applicable clinical measures.  
For example, the FM, IM and Endocrinology specialties would report on the Optimal Diabetes Care measure. |

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Hotline: 612-746-4522 | E-mail: support@mncm.org | Data Portal: https://data.mncm.org/login  
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