



2019 CMS Web Interface

PREV-6 (NQF 0034): Colorectal Cancer Screening

Measure Steward: NCQA

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INTRODUCTION

There are a total of 10 individual measures included in the 2019 CMS Web Interface targeting high-cost chronic conditions, preventive care, and patient safety. The measures documents are represented individually and contain measure specific information. The corresponding coding documents are posted separately in an Excel format.

The Measure Documents are being provided to allow group practices and Accountable Care Organizations (ACOs) an opportunity to better understand each of the 10 individual measures included in the 2019 CMS Web Interface data submission method. Each Measure Document contains information necessary to submit data through the CMS Web Interface.

Narrative specifications, supporting submission documentation, and calculation flows are provided within each document. Please review all of the measure documentation in its entirety to ensure complete understanding of these measures.

CMS WEB INTERFACE SAMPLING INFORMATION

BENEFICIARY SAMPLING

For more information on the sampling process and methodology please refer to the 2019 CMS Web Interface Sampling Document, which will be made available during the performance year at CMS.gov.

NARRATIVE MEASURE SPECIFICATION**DESCRIPTION:**

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

IMPROVEMENT NOTATION:

Higher score indicates better quality

INITIAL POPULATION:

Patients 50 - 75 years of age with a visit during the measurement period

DENOMINATOR:

Equals Initial Population

DENOMINATOR EXCLUSIONS:

Patients with a diagnosis or past history of total colectomy or colorectal cancer

OR

Patients age 65 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 any time during the measurement period

DENOMINATOR EXCEPTIONS:

None

NUMERATOR:

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

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

NUMERATOR EXCLUSIONS:

Not Applicable

DEFINITION:

None

GUIDANCE:

Do not count DRE, FOBT tests performed in an office setting or performed on a sample collected via DRE.

SUBMISSION GUIDANCE

PATIENT CONFIRMATION

Establishing patient eligibility for submission requires the following:

- Determine if the patient's medical record can be found
 - If you can locate the medical record select "Yes"
- OR**
- If you cannot locate the medical record select "No - Medical Record Not Found"
- OR**
- Determine if the patient is qualified for the sample
 - If the patient is deceased, in hospice, moved out of the country or did not have Fee-for-Service (FFS) Medicare as their primary payer select "Not Qualified for Sample", select the applicable reason from the provided drop-down menu, and enter the date the patient became ineligible

Guidance Patient Confirmation

If "No – Medical Record Not Found" or "Not Qualified for Sample" is selected, the patient is completed but not confirmed. The patient will be "skipped" and another patient must be reported in their place, if available. The CMS Web Interface will automatically skip any patient for whom "No – Medical Record Not Found" or "Not Qualified for Sample" is selected in all other measures into which they have been sampled.

If "Not Qualified for Sample" is selected and the date is unknown, you may enter the last date of the measurement period (i.e., 12/31/2019).

The Measurement Period is defined as January 1 – December 31, 2019.

NOTE:

- **In Hospice:** Select this option if the patient is not qualified for sample due to being in hospice care at any time during the measurement period (this includes non-hospice patients receiving palliative goals or comfort care)
- **Moved out of Country:** Select this option if the patient is not qualified for sample because they moved out of the country any time during the measurement period
- **Deceased:** Select this option if the patient died during the measurement period
- **Non-FFS Medicare:** Select this option if the patient was enrolled in Non-FFS Medicare at any time during the measurement period (i.e., commercial payers, Medicare Advantage, Non-FFS Medicare, HMOs, etc.) This exclusion is intended to remove beneficiaries for whom Fee-for-Service Medicare is not the primary payer.

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient is qualified for the measure
 - If the patient is qualified for this measure select “Yes”

OR

- If there is a denominator exclusion for patient disqualification from the measure select “[Denominator Exclusion](#)”

OR

- If there is an “other” CMS approved reason for patient disqualification from the measure select “No - Other CMS Approved Reason”

Denominator Exclusion codes can be found in the 2019 CMS Web Interface PREV Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance *Denominator*

If “Denominator Exclusion” or “No – Other CMS Approved Reason” is selected, the patient will be “skipped” and another patient must be reported in their place, if available. The patient will only be removed from the measure for which one of these options was selected, not all CMS Web Interface measures.

***CMS Approved Reason** may only be selected when approved by CMS. To request a CMS Approved Reason, you would need to provide the patient rank, measure, and reason for request in a Quality Payment Program Service Desk inquiry. A CMS decision will be provided in the resolution of the inquiry. Patients for whom a CMS Approved Reason is selected will be “skipped” and another patient must be reported in their place, if available.*

***The intent of the exclusion** for individuals age 65 and older residing in long-term care facilities, including nursing homes, is to exclude individuals who may have limited life expectancy and increased frailty where the benefit of the process may not exceed the risks. This exclusion is not intended as a clinical recommendation regarding whether the measures process is inappropriate for specific populations, instead the exclusions allows clinicians to engage in shared decision making with patients about the benefits and risks of screening when an individual has limited life expectancy.*

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if colorectal cancer screening is current during the measurement period.
 - If colorectal cancer screening is current select “Yes”

OR

- If colorectal cancer screening is not current select “No”

Numerator codes can be found in the 2019 CMS Web Interface PREV Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Numerator

NOTE:

- **FOBT:** It is up to the organization to determine whether the specific test or brand meets the definition
 - **Do not count digital rectal exams** (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE
 - **Documentation in the medical record must include both of the following:** A note indicating the date the colorectal cancer screening was performed AND the result or findings
 - **Documentation** of ‘normal’ or ‘abnormal’ is acceptable
 - **Patient Reported Requirement:** Date (year) and type of test AND result/finding
 - **Documentation of colorectal cancer screening** may be completed during a telehealth encounter
-

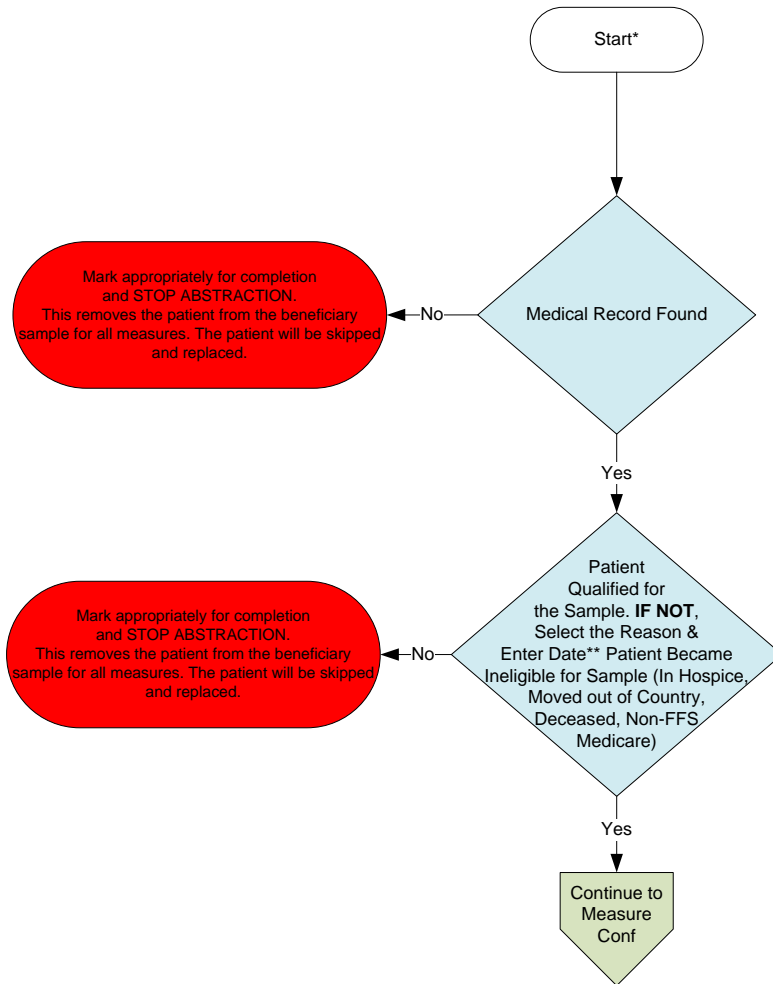
DOCUMENTATION REQUIREMENTS

When submitting data through the CMS Web Interface, the expectation is that medical record documentation is available that supports the action reported in the CMS Web Interface i.e., medical record documentation is necessary to support the information that has been submitted.

Appendix I: Performance Calculation Flow

Patient Confirmation Flow

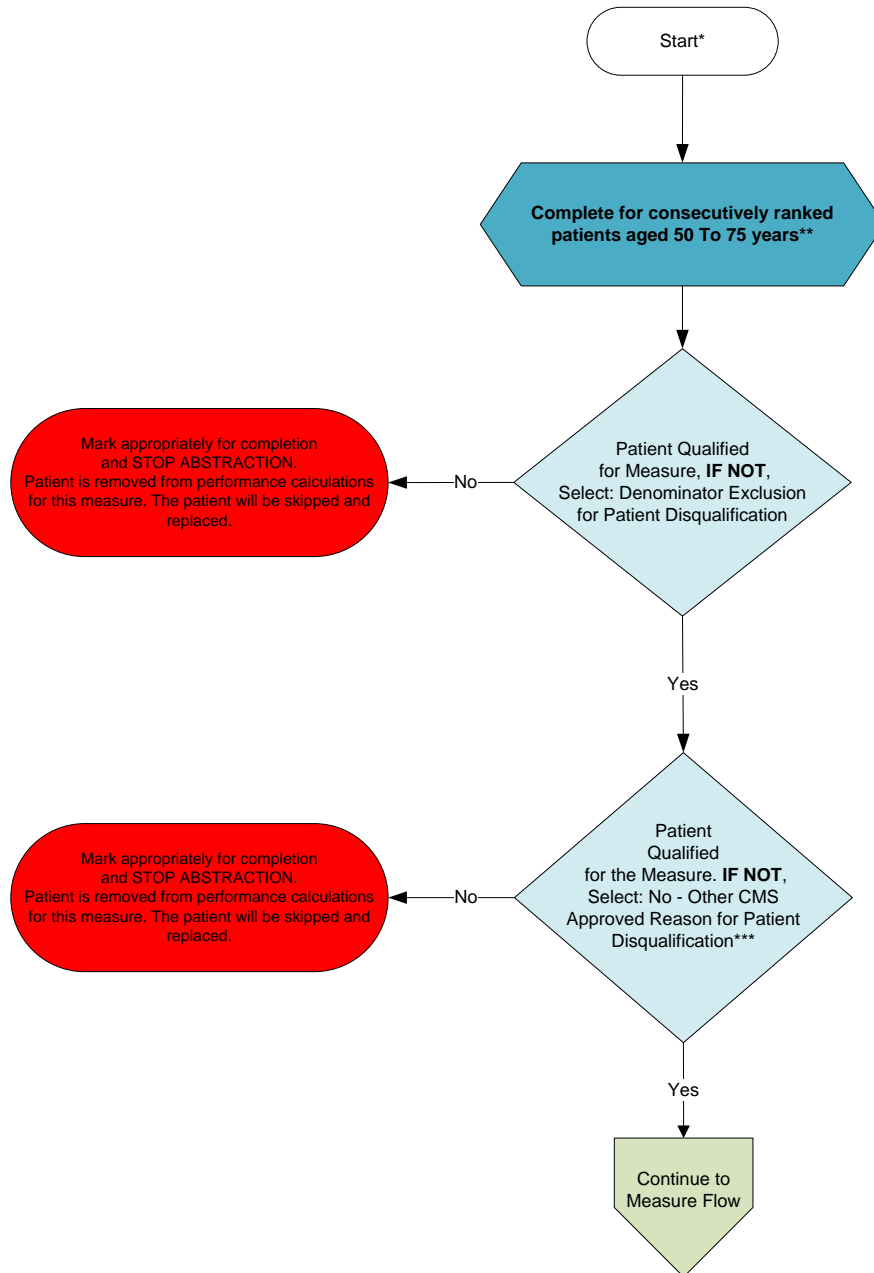
For 2019, confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "Non-FFS Medicare", will only need to be done **once** per patient.



*See the Measure Submission Document for further instructions on how to submit this measure
 **If date is unknown, enter 12/31/2019

Measure Confirmation Flow for PREV-6

For 2019, measure specific reasons a patient is “Not Confirmed” or excluded for “Denominator Exclusion” or “Other CMS Approved Reason” will need to be done for each measure where the patient appears.



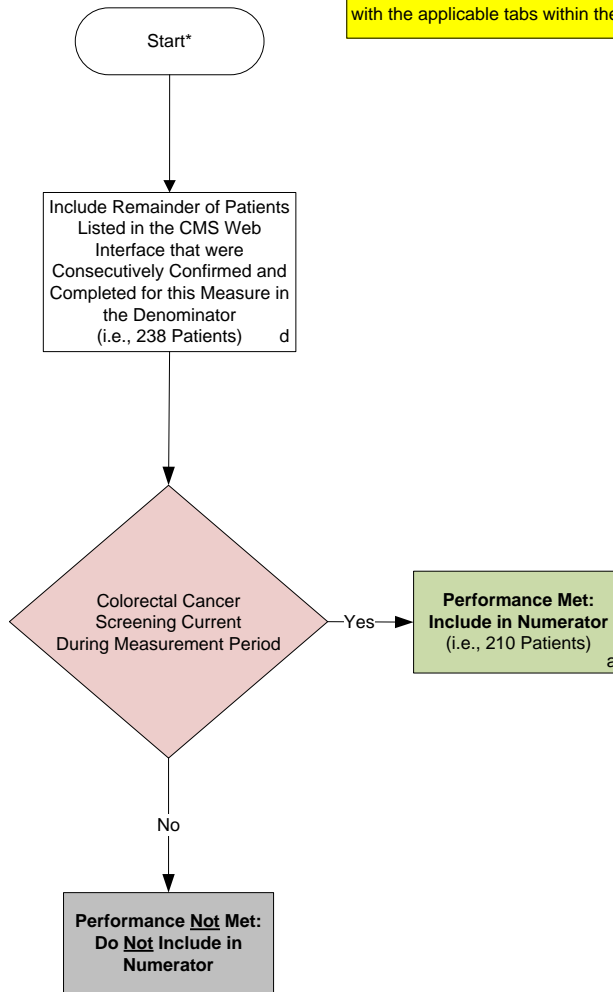
*See the Measure Submission Document for further instructions on how to submit this measure

**Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the PREV-6 measure. If this is the case, the system will automatically remove the patient from the measure requirements.

***“Other CMS Approved Reason” may only be selected if you have received an approval from CMS in the resolution of a requested Quality Payment Program Service Desk Inquiry at qpp@cms.hhs.gov

Measure Flow for PREV-6

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used as a substitution for the measure specification. For Downloadable Resource Mapping Table, go to Appendix II and use the Variable Names located in the appendix along with the applicable tabs within the PREV Coding Document.



SAMPLE CALCULATION:

Performance Rate=

$$\frac{\text{Performance Met (a=210 Patients)}}{\text{Denominator (d=238 Patients)}} = \frac{210 \text{ Patients}}{238 \text{ Patients}} = 88.24\%$$

CALCULATION MAY CHANGE PENDING PERFORMANCES MET ABOVE

*See the Measure Submission Document for further instructions on how to submit this measure

Patient Confirmation Flow

For 2019, confirmation of the “Medical Record Found”, or indicating the patient is “Not Qualified for Sample” with a reason of “In Hospice”, “Moved out of Country”, “Deceased”, or “Non-FFS Medicare”, will only need to be done **once** per patient. Refer to the Measure Submission Document for further instructions.

1. Start Patient Confirmation Flow.
2. Check to determine if Medical Record can be found.
 - a. If no, Medical Record not found, mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
 - b. If yes, Medical Record found, continue processing.
3. Check to determine if Patient Qualified for the sample.
 - a. If no, the patient does not qualify for the sample, select the reason why and enter the date (if date is unknown, enter 12/31/2019) the patient became ineligible for sample. For example; In Hospice, Moved out of Country, Deceased, Non-FFS Medicare. Mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
 - b. If yes, the patient does qualify for the sample; continue to the Measure Confirmation Flow for PREV-6.

Measure Confirmation Flow for PREV-6

For 2019, measure specific reasons a patient is “Not Confirmed” or excluded for “Denominator Exclusion” or “Other CMS Approved Reason” will need to be done for each measure where the patient appears. Refer to the Measure Submission Document for further instructions.

1. Start Measure Confirmation Flow for PREV-6. Complete for consecutively ranked patients aged 50 to 75 years. Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the PREV-6 measure. If this is the case, the system will automatically remove the patient from the measure requirements.
2. Check to determine if the patient qualifies for the measure (Denominator Exclusion).
 - a. If no, the patient does not qualify for the measure select: Denominator Exclusion for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. Stop processing.
 - b. If yes, the patient does qualify for the measure, continue processing.
3. Check to determine if the patient qualifies for the measure (Other CMS Approved Reason).
 - a. If no, the patient does not qualify for the measure select: No – Other CMS Approved Reason for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. “Other CMS Approved Reason” may only be selected if you have received an approval from CMS in the resolution of a requested Quality Payment Program Service Desk Inquiry at gpp@cms.hhs.gov. Stop processing.
 - b. If yes, the patient does qualify for the measure, continue to the PREV-6 measure flow.

Measure Flow for PREV-6

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used as a substitution for the measure specifications. For Downloadable Resource Mapping Table, go to Appendix II and use the Variable Names located in the appendix along with the applicable tabs within the PREV Coding Document.

1. Start processing 2019 PREV-6 (NQF 0034) Flow for the patients that qualified for sample in the Patient Confirmation Flow and the Measure Confirmation Flow for PREV-6. **Note:** Include remainder of patients listed in CMS Web Interface that were consecutively confirmed and completed for this measure in the denominator. For the sample calculation in the flow these patients would fall into the 'd' category (eligible denominator, i.e. 238 patients).
2. Check to determine if the patient's colorectal cancer screening is current during the measurement period.
 - a. If no, the patient's colorectal cancer screening is not current during the measurement period; performance is not met and the patient should not be included in the numerator. Stop processing.
 - b. If yes, the patient's colorectal cancer screening is current during the measurement period, performance is met and the patient will be included in the numerator. For the sample calculation in the flow these patients would fall into the 'a' category (numerator, i.e. 210 patients). Stop processing.

Sample Calculation

Performance Rate Equals

Performance Met is category 'a' in the measure flow (210 patients)

Denominator is category 'd' in the measure flow (238 patients)

210 (Performance Met) divided by 238 (Denominator) equals a performance rate of 88.24 percent

Calculation May Change Pending Performance Met

Appendix II: Downloadable Resource Mapping Table

Each data element within this measure’s denominator or numerator is defined as a pre-determined set of clinical codes. These codes can be found in the 2019 CMS Web Interface PREV Coding Document.

***PREV-6 Colorectal Cancer Screening**

Measure Component/Excel Tab	Data Element	Variable Name	Coding System(s)
Denominator Exclusion/ Denominator Exclusion Codes	Exclusion	COLON_CANCER_CODE	I9 I10 SNM
		TOTAL_COLECTOMY_CODE	C4 SNM
Numerator/Numerator Codes	Colorectal Cancer Screening	FOBT_CODE	LN
		FLEX_SIG_CODE	C4 HCPCS SNM
		COLONOSCOPY_CODE	C4 HCPCS SNM
		CT_COLONOGRAPHY_CODE	C4 SNM
		FIT_DNA_CODE	LN

** For EHR mapping, the coding within PREV-6 is considered to be all inclusive*

Appendix III: Measure Rationale and Clinical Recommendation Statements**RATIONALE:**

Colorectal cancer represents 8 percent of all new cancer cases and is the second leading cause of cancer deaths in the United States. In 2017, there were an estimated 135,430 new cases of colorectal cancer and an estimated 50,260 deaths attributed to it. According to the National Cancer Institute, about 4.3 percent of men and women will be diagnosed with colorectal cancer at some point during their lifetimes. For most adults, older age is the most important risk factor for colorectal cancer, although being male and black are also associated with higher incidence and mortality. Colorectal cancer is most frequently diagnosed among people 65 to 74 years old (Howlader et al. 2017).

Screening can be effective for finding precancerous lesions (polyps) that could later become malignant, and for detecting early cancers that can be more easily and effectively treated. Precancerous polyps usually take about 10 to 15 years to develop into colorectal cancer, and most can be found and removed before turning into cancer. The five-year relative survival rate for people whose colorectal cancer is found in the early stage before it has spread is about 90 percent (American Cancer Society 2017).

CLINICAL RECOMMENDATION STATEMENTS:

The U. S. Preventive Services Task Force (2016) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. This is a Grade A recommendation (U.S. Preventive Services Task Force 2016).

Screening tests:

- Colonoscopy (every 10 years)
- Flexible sigmoidoscopy (every 5 years)
- Fecal occult blood test (annually)
- FIT-DNA (every 3 years)
- Computed tomographic colonography (every 5 years)

Appendix IV: Use Notices, Copyrights, and Disclaimers

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