Q: Which members are included in the sample?

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

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Q: What codes are used?

A: Codes to Identify Colorectal Cancer Screening:

<table>
<thead>
<tr>
<th>Test</th>
<th>CPT</th>
<th>HCPCS</th>
<th>ICD-9 Dx</th>
<th>ICD-9 Procedure</th>
<th>LOINC</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOBT</td>
<td>82270, 82274</td>
<td></td>
<td>G0328,</td>
<td></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</td>
</tr>
<tr>
<td>Flexible Sig</td>
<td>45330-45335, 45337-45342, 45345</td>
<td>G0104</td>
<td>45.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>44388-44394, 43977, 45355, 45378-45387, 45391, 45392</td>
<td>G0105, G0121</td>
<td>45.22, 45.23, 45.25, 45.42, 45.43</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Q: What documentation is needed in the medical record?

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

- FOBT in 2011; either guaiac (gFOBT) or immunochemical (iFOBT)
- Colonoscopy in 2011 or within 9 years prior to 2011.

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Q: What type of medical record is acceptable?

A: One or more of the following:

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

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Q: How to improve score for this HEDIS measure?

A:

- Use of correct diagnosis and procedure codes
- Timely submission of claims and encounter data
- Ensure presence of ALL components in the medical record documentation