ASC-10 FACT SHEET

ASC-10: ENDOSCOPY/POLYP SURVEILLANCE: COLONOSCOPY INTERVAL FOR PATIENTS WITH A HISTORY OF ADENOMATOUS POLYPS – AVOIDANCE OF INAPPROPRIATE USE

Description: Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings, who had a follow-up interval of three or more years since their last colonoscopy

Denominator: All patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings

Numerator: Patients who had an interval of three or more years since their last colonoscopy

- DO use any medical reason, such as a diagnosis, symptom, or condition that is documented in the medical record, to exclude a case from the denominator population. Please remember that there is no comprehensive list of medical reasons. Some examples are:
  - Moderate risk for colon cancer due to personal or family history of cancer
  - “High risk” patients
  - Diverticulosis and hemorrhoids
  - Poor prep or poor visualization
  - Acute symptoms, such as rectal bleeding, abdominal pain, or change in bowel habits

- DO utilize the system reason of “unable to locate the previous colonoscopy report” to exclude a case from the denominator when it is clearly documented in the current medical record.

- DO use past medical history for abstraction if the documentation is restated or is entered into the current medical record.

- DO calculate the time interval between colonoscopies according to the specificity of the date of the previous colonoscopy. If the date of the prior colonoscopy is reported in a day/month/year format, then the follow-up interval should be determined according to the specific day, month, and year of the previous colonoscopy. If the previous colonoscopy was reported in a month/year format, then the follow-up interval should be calculated according to the month and year of the previous colonoscopy. If only a year is provided, then three years from the given year is acceptable.

  If there is no documentation of the interval of the last colonoscopy and no documented medical reason for excluding the patient from the denominator (assuming the patient meets the denominator requirements), the patient will be in the denominator and excluded from the numerator.

- DO NOT use “history of colonic polyps” as a medical reason to exclude records from the denominator. A patient must have a history of colonic polyps to be eligible for the measure.

- DO NOT include records with CPT/HCPCS modifiers 52, 53, 73, or 74.