



Colonoscopy (COLOS) ECR Playbook
ECR Definition Summary

	Definition
Trigger Codes*	The patient has an <u>outpatient facility or professional claim</u> with 1) any of these ICD-9-CM procedure codes in any position: 45.2y, y=3,4,5,7 45.42 or any of these CPT codes in any position: G0105, G0121, 45330, 45341, 45378, 45391, 45332, 45334:45337, 45340, 45345, 45379, 45381:45382, 45386:45387, 45392, 45331, 45333, 45338:45339, 45342, 45380, 45383:45385, 45392 AND 2) any of these qualifying ICD-9-CM diagnosis codes in any position in the outpatient facility claim: v76.5y, y=0,1, v76.4y, y=1,9, v10.0y, y=5,6, v16.0, v12.72, 562.y0, y=0,1, 564.xx, 751.0, 569.0, 211.y, y=3,4, 562.y2, y=0,1, 569.3, 578.y, y=1,9, 792.1, 787.9y, y=1,9, 455.xx, 28y.xx, y=0,1,5, 562.0y, y=1,3, 562.1y, y=1,3, 55y.xx, y=5,6, 557.xx, 558.xx, 569.8y, y=4,5,9, 569.9
Episode Time Window	From 7 days prior to the index admission date to 30 days after index discharge date
Enrollment / eligibility requirement	Duration of episode (7-day look-back period, duration of facility stay and 30-day look-forward period) with a maximum of continuous 30-day gap
Patient Exclusions	1. Enrollment criteria not met 2. Age < 18 or Age >= 65 years 3. Discharge status is left against medical advice 4. In-hospital death 5. Does not have both an outpatient index stay and a relevant professional claim (orphan episode)
Claim/Episode charge exclusions	1. Remove PFO [†] claims if the claim charges are missing, < \$10, or >\$1,000,000 2. Remove Stay claims if claim charges are missing, < \$50, or >\$1,000,000 3. Remove Pharmacy claims if claim charges are missing, < \$1, or >\$1,000,000 4. Remove episode if total medical charges for the episode are < \$20 or > \$1,000,000 5. Remove episode if total pharmacy charges for the episode are < \$1 or > \$1,000,000
Medical exclusions	HIV, cancer, suicide, end-stage renal disease (ESRD), pregnancy and newborn conditions
Procedural exclusions	Exclude claims with select major or irrelevant surgical procedures such as transplants etc., as indicated in the “all codes” workbook

	Definition
Potentially Avoidable Complications (PACs) – this includes CMS defined hospital acquired conditions (HACs), AHRQ’s patient safety indicators and more	<p>Index outpatient facility claims could be considered as having a PAC if they are one of three types:</p> <ol style="list-style-type: none"> 1. PACs related to the index condition: The index procedure is regarded as having a PAC if during the index stay the patient develops one or more complications related to the primary procedure such as peritonitis, bleeding, perforation, etc. 2. PACs due to Comorbidities: The index stay is also regarded as having a PAC if one or more of the patient’s controlled comorbid conditions is exacerbated during the stay (i.e. it was not present on admission). Examples of these PACs are diabetic emergency with hypo- or hyperglycemia, pneumonia, lung complications gastritis, ulcer, GI hemorrhage etc. 3. PACs suggesting Patient Safety Failures: The index stay is regarded as having a PAC if there are one or more complications related to patient safety issues. Examples of these PACs are septicemia, other infections, phlebitis, deep vein thrombosis, pulmonary embolism or any of the CMS-defined hospital acquired conditions (HACs). <p>All inpatient readmissions are considered as PACs. In addition, professional claims as well as outpatient facility admissions are considered as typical or having a PAC based on the codes on these claims.</p>
Type of model(s) developed	<ol style="list-style-type: none"> 1. Outpatient facility model: Model for ages 18 to <65 year olds. 2. Professional, pharmacy & all other claims model: Model for ages 18 to <65 year olds.

* x = any digit from 0-9 inclusive or blank, y is as indicated.

† PFO: Professional, outpatient facility, ancillary and other claims