

Measure at a Glance

CBE #3510: Screening/Surveillance Colonoscopy

Measure Summary (Where does this measure seek to improve care?)

This measure looks at the cost of care for people who receive a colonoscopy. A colonoscopy is a test that allows doctors to look inside the large intestine (colon). The measure focuses on Medicare patients and can capture how much care costs at two levels of analysis: individual clinician and clinician group/practice. The measure includes care from the day of the procedure through 14 days after. This full period of care is called an episode. The measure uses a cost comparison approach. It compares the actual cost (observed cost) to an expected cost that accounts for patient health differences. The final score shows the average cost per episode for each clinician or group/practice. A lower-than-average score means costs are lower than expected, while a higher-than-average score means costs are higher than expected.

Meaningfulness (Why does this matter to patients, and how could it improve their care?)

This measure focuses on people who receive a colonoscopy and the clinicians who provide care. The Centers for Medicare & Medicaid Services (CMS) gathered input from 15 patients and caregivers to identify what makes a cost measure useful for decision-making. These criteria include helping many people, supporting quality of life, linking to quality measures, helping care decisions, and reducing unnecessary costs. This measure meets those criteria.

A colonoscopy is usually planned, so patients may have time to review cost information before the procedure. Patients noted that cost information may be more helpful when combined with quality information. They also noted that patients may have limited knowledge of Medicare costs beyond what they pay out-of-pocket. This measure may support understanding of cost differences across providers.

Usability (How will providers use this measure to improve care delivery?)

CMS uses this measure in a national program to compare cost across clinicians and groups/practices. The measure is part of a system that provides performance scores and feedback reports. These reports include cost data, comparisons to national averages, and details about each episode of care. Clinicians can review this information through the Quality Payment Program (QPP) portal.

Clinicians and groups/practices received performance reports and provided feedback during measure development and testing. In 2017, 6,739 groups and 19,085 clinicians received reports. Feedback included 219 survey responses, 53 comment letters, and participation from approximately 1,000 clinicians in feedback calls. This input resulted in updates such as revisions to procedure codes, care settings, and exclusions, which may improve the measure's clarity and usability.

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Feasibility (How can this measure be implemented without adding burden for providers and patients while still improving care?)

This measure relies on claims data, which are billing records created during routine care. These data include diagnosis codes, procedure codes, service dates, and payment amounts. Because Medicare systems already collect the data, clinicians and groups do not need to record or submit new information. The measure is calculated using structured electronic data, so no manual chart review is required.

CMS completes all data processing and reporting. Clinicians do not need to change how they deliver care or document visits. Patients do not provide extra information or complete surveys. The measure uses a 2-month period after the end of the year to allow claims to be finalized before calculation. This approach may reduce burden and support consistent data collection across all clinicians and groups.

Impact (How will using this measure improve patient experiences and outcomes?)

For patients, this measure may provide information about how costs vary between providers. Because colonoscopies are usually planned, patients may have time to review cost information before receiving care. This measure may also support discussions between patients and clinicians about care choices. However, the measure focuses on cost only and does not include all aspects of care quality.

Cost differences can come from factors such as bowel preparation quality, use of anesthesia, repeat procedures, and complications. These factors occur during the procedure or within the 14 days following the procedure. This measure may help show how these factors link to higher or lower costs.

Performance Gap (Based on current performance, where and how much care can improve?)

In 2024, the average cost per episode (which includes care from the day of the procedure through 14 days after) was \$1,173. Percentiles show how these costs compare across all providers from lowest to highest. For example, costs were about \$730 at the 10th percentile, meaning these are lower-cost episodes (about 10 out of 100 episodes cost less, while most cost more). Costs were about \$1,568 at the 90th percentile, meaning these are higher-cost episodes (most episodes cost less, and only a few cost more). The full range was from \$166 to \$2,943. This wide variation means some clinicians and groups have higher or lower costs for similar care.

The measure compares each clinician or group to others in the same care setting. Because results are compared to other providers, the measure shows differences across the system rather than setting a fixed target.

Disclaimer: Battelle used generative artificial intelligence in the initial drafting of this document. Actual humans with relevant expertise subsequently validated and revised the content.