Colorectal Cancer Screening Tips

HEDIS® Measure: Patients ages 45 to 75 should have one of the following screenings for colorectal cancer:

- Fecal occult blood test (FOBT) within the past year
- Flexible sigmoidoscopy in the past five years
- Colonoscopy in the past 10 years
- Fecal immunochemical test (FIT) DNA test in the past three years

Coding	CPT® Codes	HCPCS	ICD-10-PCS/CM	Lab Extracts
Colonoscopy	44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398	G0105, G0121	N/A	N/A
CT Colonography	74261-74263	N/A	N/A	N/A
FIT DNA Test	81528	N/A	N/A	77353-1, 77354-9
Sigmoidoscopy	45330-45335, 45337-45338, 45340-45342, 45346-45347, 45349-45390	G0104	N/A	N/A
FOBT	82270, 82274	G0328	N/A	12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6
Colorectal cancer		G0213-G0215, G0231	C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048	N/A
Total colectomy	44150-44158, 44210-44212		0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ	N/A

Recommendations to Improve Performance

Develop/implement a Flu-FIT/FOBT campaign by offering these kits to eligible patients at the time of their annual flu shots. Coach patients on how to use the kits, track test results, and follow-up.

Develop standing orders and engage office staff to champion screening reminders and distribute FIT or FOBT kits to patients who are due for a colorectal cancer screening or prepare referral for colonoscopy.

Audit claims for proper codes and provide education for staff on coding as indicated. Verify that capitated providers are submitting records of service provided. Submit supplemental data or chart showing service.

Do not count digital rectal exam (DRE), or FOBT test performed in an office setting or on a sample collected via DRE, as evidence of a colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.

Ensure proper documentation of appropriate screening in patient's medical record:

Indicate date, type of screening, and result. If clear documentation is part of the medical history section of the record, then date of service and type of test alone is acceptable.