Colorectal Cancer Screening Tips

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Patients ages 45–75 should have one of the following screenings for colorectal cancer:

- Fecal occult blood test (FOBT) in the current year
- Flexible sigmoidoscopy in the current year or four years prior
- Colonoscopy in the current year or nine years prior
- Fecal immunochemical DNA test (FIT-DNA)
- CT colonography in the current year or four years prior

Not recommended for members who had colorectal cancer or a total colectomy anytime during the member's history through December 31 of the measurement year; members in hospice or using hospice services anytime during the measurement year; members who died anytime during the measurement year; or members receiving palliative care (ICD-10-CM Z51.5) anytime during the measurement year.

Coding	CPT® Codes	HCPCS Codes	ICD-10-PCS/CM Codes	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	60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
FIT-DNA	81528	N/A	N/A	77353-1, 77354-9
Flexible 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, 57904-2, 58453-2, 80372-6

Members are excluded if either of the following occur at any time during the member's history through December 31 of the current year:

Coding	CPT® Codes	HCPCS Codes	ICD-10-PCS/CM Codes	Lab Extracts
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 FIT-DNA or FOBT campaign by offering these kits to eligible patients at the time of their annual exams.

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 distributeFIT-DNA 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. 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.

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Recommendations to improve performance:

Give patients colorectal cancer screening options and inform them that colorectal cancer screening is a covered preventive service.

Clearly document in the medical record if patient has a history of colorectal cancer or had a total colectomy (exclusions).

Submit claims and encounter data in a timely manner. Refer to recommended codes above.

Document screening in medical history section of the record and update the section annually regarding colorectal cancer screening (test done and date).

General coding tips:

- Ensure the signature on the medical record (such as chart notes and progress notes) is legible and includes the signee's credentials.
- For electronic health records, confirm that all electronic signature, date, and time fields are completed. Include qualifying phrases such as "authenticated by," "verified by," or "generated by."
- Make sure the physician documents to the highest degree of specificity in the medical record.
- Assign the ICD-10 code that includes the highest degree of specificity.
- Include proper causal or link language to support the highest degree of specificity in diagnosis and coding.
- Verify that the billed diagnosis codes are consistent with the written description on the medical record.
- Include whether the diagnoses are being monitored, evaluated, assessed/addressed, and treated (MEAT) in the documentation.
- If a chronic condition is currently present in a member, do not use language such as "history of."
- On the medical record, document all chronic conditions present in the member during each visit.
- At least once per year, submit all chronic diagnosis codes based on documentation in a claim.

NOTE: The information listed here is not all-inclusive and is to be used as a reference only. Please refer to current ICD-10/CPT/HCPCS coding and documentation guidelines at cms.gov. HEDIS® measures can be found at ncqa.com.