Colorectal Cancer Screening Tips

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Colorectal Cancer Screening HEDIS® measure: Patients ages 50 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
- FIT DNA test in the past 3 years

Not Recommended for patients with a history of colorectal cancer or total colectomy.

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	G0464	N/A	77353-1, 77354-9
Sigmoidoscopy	45330-45335, 45337, 45342, 45345-45347, 45349-45350	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 fecal immunochemical test (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 performed 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.

If you would like additional resources, contact our Provider Relations team at Providers@ARHealthWellness.com

NOTE: The information listed here is not all inclusive and is to be used as a reference only. Please refer to current IDC-10/CPT/HCPCS Coding and Documentation Guidelines found at www.cms.gov. HEDIS Measures can be found at www.ncqa.com

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Recommendations to Improve Performance Continued

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

Clearly document in 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

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

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