

Colorectal Cancer Screening (COL-E)

MEASURE DESCRIPTION

Persons 45-75 years of age who had appropriate screening for colorectal cancer:

Screening	Time frame
<ul style="list-style-type: none"> Fecal occult blood test 	During the measurement period
<ul style="list-style-type: none"> Stool DNA (sDNA) with FIT test 	During the measurement period or the two years prior to the measurement period
<ul style="list-style-type: none"> Flexible sigmoidoscopy CT colonography 	During the measurement period or the four years prior to the measurement period
<ul style="list-style-type: none"> Colonoscopy 	During the measurement period or the nine years prior to the measurement period ¹

EXCLUSIONS

Persons are excluded if the following apply:

Exclusion	Time frame
<ul style="list-style-type: none"> Date of death Hospice or use of hospice services Palliative care Medicare enrollees, 66 years of age and older, in an institutional SNP (I-SNP) or living long-term in an institution (LTI) 66 years of age or older with both frailty and advanced illness; for additional definition information, see the Advanced Illness and Frailty Exclusions Guide <ul style="list-style-type: none"> Frailty: At least two indications of frailty with difference dates of service during the measurement period Advanced illness or dispensed dementia medication during the measurement period or the year prior to the measurement period 	Any time during the measurement period
<ul style="list-style-type: none"> History of colorectal cancer; cancer of the small intestine Total colectomy; partial or hemicolectomies 	Any time during the person's history through December 31 of the measurement period

CODING²

For exclusions, use the appropriate code:

Colorectal cancer and history of colorectal cancer	
ICD10CM ³	C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Total colectomy	
CPT® I/II ⁴	44150, 44151, 44152, 44153, 44155, 44156, 44157, 44158, 44210, 44211, 44212
ICD10PCS	0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

For screenings, use the appropriate code:

Fecal occult blood test	
CPT I/II	82270, 82274

HCPCS ⁵	G0328
LOINC ⁶	104738-0, 107189-3, 107190-1, 107191-9, 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
Stool DNA (sDNA) with FIT test	
CPT I/II	81528, 0464U
LOINC	77353-1, 77354-9
Flexible sigmoidoscopy	
CPT I/II	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350
HCPCS	G0104
CT colonography	
CPT I/II	74261, 74262, 74263
LOINC	60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
Colonoscopy	
CPT I/II	44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398
HCPCS	G0105, G0121

TIPS FOR SUCCESS

Patient care

- Educate patients regarding the benefit of early detection of colorectal cancer and review all screening options
 - The best screening is the one the patient will get; patients who are given a choice between colonoscopy and fecal testing, and who review the pros and cons of each with their provider, are more likely to complete the screening. Consider patient risk when evaluating options
 - Have FIT kits readily available to give patients during the visit with instructions to return them to the office or mail to the lab; mail patients a home test kit if they are willing to complete an in-home test
- If colonoscopy is not offered at the practice, develop a relationship with a local gastroenterologist in an outpatient setting: Share outreach lists and create agreement for scheduling and result turn-around-time
- Be aware of cost barriers and surprise bills to patients when offering colorectal cancer screening
 - A colonoscopy could be subject to cost-shares if billed using diagnostic codes
 - Cologuard is processed through a lab that is frequently out-of-network for plans, resulting in high-cost shares for patients
 - FIT kits are typically considered preventive with no cost shares when processed at an in-network lab
- Educate care team on identifying barriers to care: Provide scripting for the care team and provide training on motivational interviewing and health belief systems, cultural awareness
- Implement standing orders for screening and ensure follow-up reports are received
- Performing fecal occult testing on a sample collected from a digital rectal exam (DRE) or on a stool sample collected in an office setting does not meet screening criteria.

Documentation and coding

- Patient medical records should include:
 - Colorectal cancer screening reports with date of screening and results. Pathology reports taken during a colonoscopy are also acceptable.
 - Patient reported screenings are acceptable when the date of screening and type of is documented. A result is not required if the documentation is clearly part of the patient's medical history. If this is not clear, the result or findings must also be present.

- Document medical and surgical history in the medical record with dates in structured fields; this will allow the corresponding code to be included in electronic reporting, including claims, to health plans
- Partner with your health plan payers to submit electronic data from your EMR
- This is an Electronic Clinical Data Systems (ECDS) measure. Information can only be submitted electronically (EMR extracts and FHIR feeds), through claims, or from medical records sent to the plan by the end of the measurement period. Plans cannot perform chart reviews after the measurement period for this measure.

Note: Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, and Premera Blue Cross HMO review and update tip sheets regularly to include the latest technical specification updates from NCQA.

¹ National Committee for Quality Assurance. HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans (2025), 547-552.

² This information is not intended as billing or legal guidance or for creating EMR extract files. These codes are proprietary and do not guarantee payment. Not all codes are included, and coding requirements may change. Each code should be used based on medical necessity and supported by proper documentation in the member record.

³ ICD-10 created by the National Center for Health Statistics (NCHS), under authorization by the World Health Organization (WHO). Copyright WHO.

⁴ CPT® is a registered trademark of the American Medical Association (AMA).

⁵ HCPCS codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of Centers for Medicare & Medicaid Services, America's Health Insurance Plans, and the Blue Cross Blue Shield Association).

⁶ LOINC codes are created and maintained by Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee.