Colorectal Cancer Screening

Coding Specifications

Codes required to document a visit occurred:

A CPT code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT codes

- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99304, 99305, 99306, 99307, 99308, 99309, 99310
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Quality codes for this measure:

CPT II Code descriptors

(Data collection sheet should be used to determine appropriate code.)

- ***CPT II 3017F:*** Colorectal cancer screening results documented and reviewed
- ***CPT II 3017F–1P:*** Documentation of medical reason(s) (eg, not indicated, contraindicated, other medical reason) for not performing a colorectal cancer screening
- ***CPT II 3017F–8P:*** Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified