Colorectal Cancer Screening

Coding Specifications

Codes required to document a visit occurred:

A CPT E/M service code is required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

CPT E/M service codes

- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult),
- 99304, 99305, 99306, 99307, 99308, 99309, 99310 (nursing facility),
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 (domiciliary)

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) for not performing a colorectal cancer screening
- ***CPT II 3017F–8P:*** Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified