Priority Health	BILLING POLICY No.121
COLORECTAL CANCER SCREENING	
Date of origin: Aug. 2025	**Review dates: 4/2026, 8/2026**

POLICY OVERVIEW

This policy outlines billing and payment requirements associated with colorectal cancer screening. This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual and industry standards.

DEFINITION

Colorectal cancer (CRC) refers to cancer that begins in the colon or rectum. These cancers are often grouped together due to their similar characteristics. Early detection through screening significantly reduces CRC incidence and mortality. Screening typically begins with a preventive visit to a healthcare provider for assessment of individual risk and appropriate testing.

MEDICAL POLICY

- Colorectal Cancer Screening

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD, or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Coding Specifics

Priority Health utilizes internal and third-party code editing vendors to apply to screening or diagnostic of colon cancer procedures code editing to professional and outpatient facility claims. The edits may be sourced from the Centers for Medicare and Medicaid Services (CMS), regional carrier LCDs and Articles, the American Medical Association (AMA) Current Procedural Terminology (CPT®), HCPCS, ICD-10 publications, or the Food and Drug Administration (FDA). The edits are to ensure accuracy of claims data, to be HIPAA compliant, to address potential Fraud, Waste and Abuse, and to ensure accurate and fair reimbursement for members and providers.

Colonoscopy

- Age range: 45-75 years
- Frequency: Once every 10 years

Flexible Sigmoidoscopy

- Age range: 45-75 years
- Frequency: Once every 5 years

Computed Tomography Colonography (CTC)

- Authorization is required: To access EviCore clinical guidelines, log in to Priority Health Prism/ Authorizations /Authorization Criteria Lookup.

Cologuard® (Exact Sciences Corp.)

- Prior authorization through EviCore is required.
- To access EviCore clinical guidelines: Log into Priority Health Prism/Authorizations Authorization/ Criteria Lookup.
- See medical criteria in PH Medical Policy: **Colorectal Cancer Screening**

Cologuard Plus™ (Exact Sciences Corp.)

- Age range: 45-75 years
- Frequency: Once every 3 years
- See medical criteria in PH Medical Policy: **Colorectal Cancer Screening**

Fecal occult blood test (FOBT)

- Age range: 45-75 years
- Frequency: annually

Shield™ (Guardant Health Inc.)

- **Computer or artificial intelligence aided colonoscopy**

- Managed by EviCore. To access EviCore clinical guidelines: Log into Priority Health Prism/Authorizations Authorization/ Criteria Lookup. (Lab Management Program).

Non-covered screening tests (per PH Medical Policy: **Colorectal Cancer Screening**)

- Magnetic resonance imaging (MRI) colonography
- Wireless Capsule Endoscopy (WCE)

Modifiers

Priority Health follows standard billing and coding guidelines, which include CMS NCCI. Modifiers should be applied when applicable, based on this guidance, and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Applicable Colorectal Screening codes as indicated in Priority Health Medical Policy, **Colorectal Cancer Screening**, billed with modifier 33 - Preventive Services or modifier PT - Colorectal cancer screening test; converted to a diagnostic test or other procedure will process as a preventive benefit regardless of diagnosis.

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Diagnosis

Please review PH Medical Policy: **Colorectal Cancer Screening** for information regarding appropriate screening diagnosis codes and preventive guidelines for the below services.

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Reimbursement specifics
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

FAQ

Related policies

Screening for Colorectal Cancer | Colorectal Cancer | CDC

https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=281

Related denial language

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies, and other services or items for coverage under a member's benefit plan or authorization is not being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis, and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste, and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies, and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align with these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim

payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
April 2026	New Policy
August 2026	Added age range and frequency language for Cologuard plus. Also added the coding specific overview and removed the authorization language.