Priority Health	BILLING POLICY No.121
COLORECTAL CANCER SCREENING	
Date of origin: Aug. 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

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

Diagnosis

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

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 into Priority Health Prism - Authorizations - Authorization Criteria Lookup.

Cologuard® (Exact Sciences Corp.)

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

Cologuard Plus™ (Exact Sciences Corp.)

- Authorization is required: To access EviCore clinical guidelines: Log into Priority Health Prism - Authorizations - Authorization Criteria Lookup.

Fecal occult blood test (FOBT)

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

Shield™ (Guardant Health Inc.)

- Authorization is required: To access EviCore clinical guidelines: Log into Priority Health Prism - Authorizations - Authorization Criteria Lookup.

Computer or artificial intelligence aided colonoscopy

- Not separately payable

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

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

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 of any applicable defined guidelines.

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 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.

Reimbursement rates

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).

REFERENCES

Screening for Colorectal Cancer | Colorectal Cancer | CDC

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

DISCLAIMER

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 isn't 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 standard, 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 for services rendered or items supplied will result in a 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 to 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