AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Colorectal Cancer

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Colorectal cancer (CRC) is a malignant neoplasm arising from the epithelial lining of the colon or rectum, generally progressing through an **adenoma–carcinoma sequence** over 10–15 years. Approximately 95% are adenocarcinomas. Diagnosis is confirmed by colonoscopy with biopsy; staging uses the **AJCC 8th Edition TNM system**. All newly diagnosed CRC should undergo universal **MMR/MSI testing** and **DPYD pharmacogenomic testing** before fluoropyrimidine use.[1,2]

ICD-10 Codes: **C18.0–C18.9** (colon by anatomic site; avoid C18.9 unspecified) · **C19** (rectosigmoid junction) · **C20** (rectum) · **C78.7** (liver metastasis) · **C78.0x** (lung metastasis) · **C79.51** (bone metastasis) · **C78.6** (peritoneal metastasis). **Z85.038/Z85.048** (personal history after confirmed treatment completion with NED). **Z93.3/Z93.4** (colostomy/ileostomy status → HCC 463). **G62.0** (oxaliplatin neuropathy). Active disease during surveillance = C18.x, **not Z85.x**.[3,4]

HCC/RAF V28 Mapping

ICD-10 CODE[3,4]	HCC CATEGORY	RAF WEIGHT	DOCUMENTATION REQUIREMENT
C18.0–C18.8, C19, C20 (Active CRC; Primary)	HCC 22	0.363	**Site-specific code required**. C18.9 (unspecified) acceptable only if anatomy is **genuinely unknown**. Applies during active treatment AND surveillance
C78.x (Secondary; Liver/Lung/ Peritoneum)	HCC 17	4.209	Code each active metastatic site **separately**. C78.7 = liver; C78.0x = lung; C78.6 = peritoneum. Each contributes independently
C79.51 (Secondary; Bone)	HCC 18	2.341	Document bone metastasis with active management evidence (pain, imaging, bisphosphonates). Code alongside primary malignancy
Z93.2/Z93.3 (Ileostomy/ Colostomy)	HCC 463	0.673	Document as active condition at every visit, not as a resolved historical finding. Include in problem list and MEAT
Z85.038/Z85.048 (Personal History — NED)	None	—	Use ONLY after oncology confirms treatment complete with no evidence of disease. Transition from C18.x is clinically significant

ABBREVIATIONS: CRC = colorectal cancer; HCC = hierarchical condition category; NED = no evidence of disease; RAF = risk adjustment factor; TNM = tumor-node-metastasis; RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2024 CMS-HCC model; values vary across patient populations based on eligibility and care setting

Risk-Adjusted Care Resources per Patient/Year[3,4]

Risk-adjusted care resource allocation — MA base rate × RAF coefficient; HCC 463 (ostomy)

Stage I–II (Localized)	Stage III (Regional)	Stage IV (Metastatic)	With Ostomy (+HCC 463)
$30K–$50K	**$60K–$80K**	**$150K+**	**+$10K adj**
HCC 22 · RAF 0.363	HCC 22 · +chemo costs	HCC 17/22 · RAF 4.209	Z93.3/Z93.4 · Add-on HCC

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2024 CMS-HCC model; values vary across patient populations based on eligibility and care setting.

Prevalence (U.S)

Approximately **153,020 new CRC cases** expected annually in the US, with ~52,550 deaths. Third most common cancer; second leading cause of cancer death. **~60% of diagnoses** occur in adults ≥65; median age 66 (colon), 63 (rectal). Incidence is **4–5× higher** in the 65–74 age group vs. 45–54. Early-onset CRC (age <50) rising by ~2% annually.[5,6]

AAVBC PERSPECTIVE

*Early colorectal cancer detection and precancerous lesion removal through **colonoscopy** represent one of the **highest-yield interventions** in value-based primary care, with profound implications for both outcomes and cost of care. Survival **exceeds 90% for localized disease** compared to ~15% for distant-stage presentation, underscoring the importance of prioritizing early, effective screening strategies. Beyond screening, optimal care requires individualized risk stratification, as current guidelines may not fully capture heterogeneity in older adults; incorporating frailty status and family history (RR ~1.76–2.26 for first-degree relatives) is essential to guide screening intensity and treatment tolerance.*

*Equally critical is the **accuracy and completeness of coding** across the full CRC care continuum, including screening, diagnosis, staging, biomarkers, treatment, complications, and survivorship. This is not a revenue exercise but a clinical requirement to **reflect true disease complexity**. Undercoding obscures risk, limits access to appropriate care coordination resources, and misaligns quality and performance measurement. Every CRC diagnosis must be supported by **annual MEAT documentation**, ensuring that disease status is actively evaluated and managed rather than carried forward as a **static condition**.*

2 RECOGNITION AND DIAGNOSIS

Colorectal cancer screening is operationalized through the **HEDIS Star measure Colorectal Cancer Screening (COL; C02)**, aligned with 2021 USPSTF recommendations[7] and guidance from the ACG[8] and ACS,[6] for Medicare **members aged 45–75**. Multiple screening modalities are

accepted for Star performance,[9] and all are covered under Medicare Part B with **$0 cost-sharing** for eligible beneficiaries, reducing access barriers. Within this framework, **colonoscopy remains the gold standard** due to its ability to both diagnose and remove precancerous lesions in a single procedure, directly preventing cancer development. Other screening technologies play a supportive role, serving as important access points for patients who are contraindicated for or initially unwilling to undergo colonoscopy, with the expectation that **abnormal results prompt timely diagnostic follow-up**.

Medicare Screenings and Billings (Patients Aged 45-75)

TEST	FREQUENCY	CPT/ HCPCS CODE	CLINICAL INDICATION
Colonoscopy (avg risk)	10 yr	G0121	**Gold standard screening procedure** for average-risk adults aged 45–75; complete to cecum with adequate bowel prep; adenoma detection rate target >35%
Colonoscopy (high risk)	2-5 yr	G0105	FHx of CRC in first-degree relative; **Lynch Syndrome**; prior advanced adenoma; IBD
Flexible Sigmoidoscopy	5 yr	G0104	Avg risk only; **distal colon only** (less-complete bowel prep); any adenoma/SSP/SSL or HP ≥1 cm → colonoscopy referral
CT Colonography	5 yr	74263	Avg risk alternative if colonoscopy declined/ contraindicated or incomplete; positive findings → colonoscopy referral
FIT	Annual	G0328	Preferred stool test; positive result → diagnostic colonoscopy ideally within 1-3 mo[10]
Guaiac FOBT (gFOBT)*	Annual	82270	Lower sensitivity/specificity than FIT; FIT preferred at program level for average-risk adults[11]
mt-sDNA (Cologuard)	3 yr	81528	Average-risk only; FDA-approved ages 45–85; 95% CRC sensitivity / 87% specificity (2nd-gen); no bowel prep, diet restrictions, or sedation; positive result → colonoscopy ideally within 1-3 mo[10]

ABBREVIATIONS: CPT = Current Procedural Terminology; FIT = Fecal Immunochemical Test; FOBT = Fecal Occult Blood Test; FHx = Family History; IBD = Inflammatory Bowel Disease; LN = Lymph Nodes; mt-sDNA = Multi-Target Stool DNA; CT = Computed Tomography *gFOBT colorectal cancer screenings are covered under Medicare Part B if performed at home

Subtle Early Signs of Early Onset CRC

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE FOR EARLY ONSET CRC
Change in bowel habits	Diarrhea, constipation, or alternating bowel habits in older adults often **misattributed to IBS**; new-onset symptoms require evaluation in adults ≥45
Hematochezia (blood in stool)	**5- to 54-fold increased CRC likelihood**;[12] do not attribute to hemorrhoids without evaluation as hemorrhoids do not exclude coexisting CRC[12,13]
Unexplained iron deficiency anemia	**HR 10.81**; particularly significant in men and postmenopausal women; complete colonoscopy + upper endoscopy before attributing to dietary iron deficiency
Unexplained weight loss (≥5 kg)	Often dismissed as medication-related or age-related in older adults; warrants prompt GI evaluation
Persistent abdominal pain (new-onset)	1.3- to 6-fold increased CRC risk;[12] especially significant if new-onset in older adult without prior GI diagnosis
Fatigue with anemia + bowel changes	Combination triples suspicion; do not attribute solely to aging or medications; refer for colonoscopy

ABBREVIATIONS: CRC = colorectal cancer; GI = gastrointestinal; HR = hazard ratio; IBS = irritable bowel syndrome; OR = odds ratio

Geriatric and Other Complicating Risk Factors

FACTOR	RISK SIGNAL	NOTES
Age ≥65	Incidence 4–5× higher than ages <49;[6] median diagnosis at age 66–69[6,14]	Individualize screening decisions at age 75–85 based on life expectancy and comorbidity; discuss cessation of screening at 85[7,13]
Frailty/ Functional Decline	CGA classification (fit/vulnerable/ frail) predicts surgical and chemotherapy tolerance; impacts surveillance intensity decisions	CGA before surgical or adjuvant therapy planning; consider reduced-intensity regimens for vulnerable/frail patients
Family History of CRC	RR 1.76–2.26 for first-degree relative history;[15] triggers earlier/ more frequent screening protocol	High-risk colonoscopy (G0105) every 2 years starting at age 40 or 10 years before youngest family member diagnosed

ABBREVIATIONS: CRC = colorectal cancer; CGA = comprehensive geriatric assessment; RR = relative risk; BMI = body mass index; MEAT = medical necessity, evaluation, assessment, treatment; A1c = glycated hemoglobin; 5-FU = 5-fluorouracil; SRR = summary relative risk; IARC = International Agency for Research on Cancer; ACS = American Cancer Society; IBD = inflammatory bowel disease; UC = ulcerative colitis; PSC = primary sclerosing cholangitis

FACTOR	RISK SIGNAL	NOTES
Obesity (BMI>30)	RR 1.1-1.5 for CRC incidence; [14,16,17] also worsens treatment tolerance and surgical outcomes	Weight management counseling; document BMI and nutritional status in MEAT; dietitian referral if BMI >35
Diabetes Mellitus	RR ~1.3 for CRC;[16] affects chemotherapy tolerance and surgical healing	Optimize A1c <8% during adjuvant therapy; monitor glucose closely with capecitabine/5-FU treatment
Excessive Alcohol Consumption	≥2 drinks/day: RR 1.21 and ≥4 drinks/day: RR 1.52 for CRC;[18] Beer-specific: **SRR 1.37** (≥2 beer/day); each **+1 beer/day → SRR 1.13**;[19] risk stronger for rectal than colon cancer	IARC Group 1 carcinogen; ~18,500 US CRC cases/year attributable to alcohol;[20] Beer and wine drive CRC risk more than liquor;[21] ACS: limit ≤2 drinks/day (men), ≤1/day(women)[22]
Inflammatory Bowel Disease (IBD) (UC/Crohn)	**RR 2.93** (1.79–4.81) for CRC;[23,24] risk correlates with disease duration and extent RR 1.7–2.5; cumulative risk ~5–7% at 30 years	GI-directed surveillance colonoscopy per IBD protocol;[24] document IBD status and dysplasia history; surveillance colonoscopy begins 8 years post-onset of IBD (annually if **PSC-IBD**);[13] Chromoendoscopy preferred; Dysplasia requires resection or surgery referral

ABBREVIATIONS: CRC = colorectal cancer; CGA = comprehensive geriatric assessment; RR = relative risk; BMI = body mass index; MEAT = medical necessity, evaluation, assessment, treatment; A1c = glycated hemoglobin; 5-FU = 5-fluorouracil; SRR = summary relative risk; IARC = International Agency for Research on Cancer; ACS = American Cancer Society; IBD = inflammatory bowel disease; UC = ulcerative colitis; PSC = primary sclerosing cholangitis

Diagnostic Thresholds

TEST/MARKER	DIAGNOSIS CRITERION	NOTES
Colonoscopy (diagnostic)	**Complete exam to cecum**; biopsy any suspicious or concerning lesion: biopsy-confirmed adenocarcinoma invading through muscularis mucosa (≥pT1);[2] 94.7% sensitivity for CRC detection[13]; adenoma sensitivity 89–95% (≥10 mm), 75–93% (≥6 mm);[13] serrated pathway precursors to ~20–30% of CRC[1,2,13,25]	**Gold standard diagnostic test**; provides tissue for pathology, staging, and MMR/MSI testing; assess for synchronous neoplasms (3–5% of CRC);[26] ADR target >35%

ABBREVIATIONS: CRC = colorectal cancer; pT1 = pathologic tumor stage T1; MMR = mismatch repair; MSI = microsatellite instability; ADR = adenoma detection rate; CT = computed tomography; C-RADS = CT Colonography Reporting and Data System; SSL = sessile serrated lesion; SSP = sessile serrated polyp; HP = hyperplastic polyp; RCT = randomized controlled trial; IRR = incidence rate ratio; FIT = fecal immunochemical test; Hb = hemoglobin; qFIT = quantitative fecal immunochemical test; gFOBT = guaiac fecal occult blood test; CEA = carcinoembryonic antigen

TEST/MARKER	DIAGNOSIS CRITERION	NOTES
CT colonography	Visualization of entire colon; sensitivity ~86% for polyps ≥6 mm[13]; polyp ≥10 mm or ≥3 polyps 6–9 mm → **colonoscopy referral** (C-RADS C3/C4)[13]; 86–100% CRC sensitivity[13]	Alternative if colonoscopy declined or contraindicated; positive findings → standard colonoscopy with biopsy; 89% sensitivity/94% specificity for **adenomas ≥10 mm**;[13] lower accuracy for sessile serrated lesions;[8] extracolonic findings require documented follow-up[13]
Flexible Sigmoidoscopy	Visualization of distal colon (rectum through sigmoid); biopsy of suspicious lesions; Adenoma, SSP/SSL any size, or HP ≥1 cm → colonoscopy referral within 9 mo[13]; 58–75% CRC sensitivity[13]	RCT-proven 24% CRC mortality reduction (IRR 0.74);[27,28] **does not evaluate proximal colon** = no significant proximal CRC mortality reduction; 92% specificity;[13] requires follow-up colonoscopy for full evaluation, staging, and treatment
FIT	Positive at **≥20 µg Hb/g** feces (US standard);[8] CRC sensitivity 74–81% (single test); 91% at **10 µg/g cutoff**;[29] advanced adenoma sensitivity 23–28% and specificity 94–96%[13]	**No dietary restrictions in advance of test**; Positive result → diagnostic colonoscopy ideally within 1-3 mo;[10] **no SSL utility** (5–16%);[8,13] median qFIT: CRC 147.8 µg/g vs. normal 43 µg/g[30]
gFOBT	Qualitative (no µg/g cutoff); guaiac-heme peroxidase reaction (positive/negative); CRC sensitivity 50–75%; advanced adenoma sensitivity 6–17%; specificity 96–99%[7,13]	Broadly replaced by FIT due to ↑ sensitivity and adherence;[11,13,30] positive result requires **follow-up colonoscopy** for confirmation; RCT-proven 32% ↓ CRC mortality (annual, 30 yr)[8]
CEA (baseline)	**Elevated (>10 ng/mL)** in ~70% of advanced CRC; **≥5 µg/mL** predictive of CRC recurrence (71% sensitivity, 88% specificity)[31]	Not sensitive enough for CRC **primary screening**; baseline value essential before surgery; used to monitor treatment response and detect recurrence[2]

ABBREVIATIONS: CRC = colorectal cancer; pT1 = pathologic tumor stage T1; MMR = mismatch repair; MSI = microsatellite instability; ADR = adenoma detection rate; CT = computed tomography; C-RADS = CT Colonography Reporting and Data System; SSL = sessile serrated lesion; SSP = sessile serrated polyp; HP = hyperplastic polyp; RCT = randomized controlled trial; IRR = incidence rate ratio; FIT = fecal immunochemical test; Hb = hemoglobin; qFIT = quantitative fecal immunochemical test; gFOBT = guaiac fecal occult blood test; CEA = carcinoembryonic antigen

CLINICAL PEARL: ELIMINATING LAG TIME AFTER POSITIVE STOOL TESTS

Follow-up colonoscopy after a positive stool-based test should occur **as soon as possible**. The NCCN recommends completion no later than 9 months, noting increased CRC risk when delayed beyond 6–10 months.[13] The AGA recommends offering a colonoscopy date within 3 months and targeting ≥95% completion within 6 months.[11] A meta-analysis of 361,637 patients found colonoscopy delayed beyond 6 months was associated with significantly higher odds of any CRC (OR 1.58) and advanced-stage disease (OR 2.16).[10]

The AAVBC supports follow-up within 1–3 months to ensure a closed-loop care model that facilitates early detection, maximizes outcomes, and minimizes costly hospital utilization associated with late-stage CRC.

Common Oversights

OVERSIGHT/ SHORTCUT	WHY IT MATTERS — WHAT TO DO INSTEAD
Attributing IDA to diet or menstruation without GI workup	IDA carries up to 9% GI malignancy rate; HR **10.81** for early-onset CRC (50y); AGA: bidirectional endoscopy (EGD + colonoscopy) before attributing to non-GI cause; NCCN: evaluate regardless of age[11,13,32]
Attributing rectal bleeding to hemorrhoids	**Hemorrhoids do not exclude CRC** (2% malignancy at colonoscopy for hematochezia);[33,34] NCCN: evaluate rectal bleeding **regardless of age**;[13] colonoscopy if symptoms persist post-hemorrhoid treatment
Relying on family history criteria alone to identify Lynch syndrome instead of universal tumor MMR/ MSI testing	LS accounts for **~3% of all CRC** and 8–15% of CRC diagnosed before age 50;[35,36] only 50% of LS patients meet Amsterdam criteria, and up to 28% are missed even by the revised Bethesda guidelines;[35,37] Population-based germline testing may identify up to 63% of LS carriers undetected by personal/ family history alone;[38] NCCN recommends universal MMR/IHC testing on all newly diagnosed CRC regardless of age;[2] germline MGPT for CRC diagnosed before age 50;[13] dMMR/MSI-H status determines eligibility for immunotherapy (pembrolizumab/nivolumab) and informs surgical extent (subtotal vs. segmental colectomy)[1,2,35]
Skipping follow-up colonoscopy after positive FIT	Positive FIT without follow-up colonoscopy is a **closed-loop failure**; AGA recommends completion ASAP and ideally within **1-3 mo**;[11] delays >9 mo: AOR 1.48–1.75 for CRC incidence[39]

ABBREVIATIONS: IDA = iron deficiency anemia; GI = gastrointestinal; CRC = colorectal cancer; HR = hazard ratio; AGA = American Gastroenterological Association; EGD = esophagogastroduodenoscopy; NCCN = National Comprehensive Cancer Network; MMR = mismatch repair; MSI = microsatellite instability; LS = Lynch Syndrome; IHC = immunohistochemistry; MGPT = multigene panel testing; dMMR = deficient mismatch repair; MSI-H = microsatellite instability–high; FIT = fecal immunochemical test; AOR = adjusted odds ratio; NED = no evidence of disease; CISNET = Cancer Intervention and Surveillance Modeling Network; HEDIS = Healthcare Effectiveness Data and Information Set; COL = colorectal cancer screening (HEDIS measure); MY = measurement year; CMS = Centers for Medicare & Medicaid Services; NCQA = National Committee for Quality Assurance; MEAT = Monitor, Evaluate, Assess, Treat; USPSTF = US Preventive Services Task Force

OVERSIGHT/ SHORTCUT	WHY IT MATTERS — WHAT TO DO INSTEAD
Using Z85.038 before confirmed NED	Active disease during surveillance should remain C18.x (**specific coding is required**); transition to Z85.038/Z85.048 only when oncology confirms **treatment complete with no evidence of disease**
Not screening average-risk adults aged 45–49	CRC incidence in ages 45–49 rose ~12%/year (2019–2022); CRC is now the #1 cancer killer in US men ≤50;[14] CISNET: 22–27 life-yrs gained per 1,000 screened age 45 vs. starting at age 50;[7] **Only ~34% of 45–49-year-olds were up to date in 2023**; NCQA expanded the HEDIS COL measure to ages 45–75 (MY 2024), making CRC screening **in this cohort** a CMS Star Rating metric[9]
Carrying forward "history of colon cancer" without updating	Must document **current disease status annually** (active, NED, or recurrent) = not just a carried-forward label; CRC must be **reassessed** by MEAT every calendar year

ABBREVIATIONS: IDA = iron deficiency anemia; GI = gastrointestinal; CRC = colorectal cancer; HR = hazard ratio; AGA = American Gastroenterological Association; EGD = esophagogastroduodenoscopy; NCCN = National Comprehensive Cancer Network; MMR = mismatch repair; MSI = microsatellite instability; LS = Lynch Syndrome; IHC = immunohistochemistry; MGPT = multigene panel testing; dMMR = deficient mismatch repair; MSI-H = microsatellite instability–high; FIT = fecal immunochemical test; AOR = adjusted odds ratio; NED = no evidence of disease; CISNET = Cancer Intervention and Surveillance Modeling Network; HEDIS = Healthcare Effectiveness Data and Information Set; COL = colorectal cancer screening (HEDIS measure); MY = measurement year; CMS = Centers for Medicare & Medicaid Services; NCQA = National Committee for Quality Assurance; MEAT = Monitor, Evaluate, Assess, Treat; USPSTF = US Preventive Services Task Force

Key Differentials in Elderly

PRESENTATION	DIFFERENTIAL	KEY TESTS
Change in bowel habits + rectal bleeding	CRC; IBD (UC, Crohn); diverticular disease; hemorrhoids; ischemic colitis; microscopic colitis	Colonoscopy with biopsy;[13] fecal calprotectin (**≥50 µg/g suggests IBD**);[40] CT abdomen/pelvis; stool cultures (*C. difficile*); CBC[41]
Iron deficiency anemia (unexplained)	CRC; celiac disease; peptic ulcer disease; upper GI malignancy; H. pylori gastritis	Bidirectional endoscopy (EGD + colonoscopy);[42] anti-tTG IgA + total IgA; *H. pylori* stool antigen; ferritin (**45 ng/mL diagnostic threshold**);[43] FOBT should not triage endoscopy[42]

ABBREVIATIONS: CRC = colorectal cancer; IBD = inflammatory bowel disease; UC = ulcerative colitis; CT = computed tomography; CBC = complete blood count; GI = gastrointestinal; EGD = esophagogastroduodenoscopy; tTG = tissue transglutaminase; IgA = immunoglobulin A; FOBT = fecal occult blood test; CAP = chest/abdomen/pelvis; ACR = American College of Radiology; CEA = carcinoembryonic antigen; CA-125 = cancer antigen 125; UWL = unintentional weight loss; CMP = comprehensive metabolic panel; TSH = thyroid-stimulating hormone; ESR = erythrocyte sedimentation rate; CRP = C-reactive protein; LDH = lactate dehydrogenase; PET = positron emission tomography

PRESENTATION	DIFFERENTIAL	KEY TESTS
New abdominal mass (palpable)	CRC; diverticular abscess; **ovarian pathology**; mesenteric lymphoma; soft tissue sarcoma	CT CAP with IV contrast; CBC, chemistry, CEA;[2] CA-125 if female; colonoscopy; biopsy if indicated; oncology consultation
Unexplained weight loss + fatigue	CRC (19–36% of UWL in older adults);[44] lymphoma; upper GI malignancy; thyroid disease; depression/frailty; adrenal insufficiency	CT CAP; colonoscopy + EGD; CBC, CMP, TSH, ESR/CRP, LDH, ferritin, FOBT;[44] CEA;[2] PET/CT if lymphoma suspected[13]

ABBREVIATIONS: CRC = colorectal cancer; IBD = inflammatory bowel disease; UC = ulcerative colitis; CT = computed tomography; CBC = complete blood count; GI = gastrointestinal; EGD = esophagogastroduodenoscopy; tTG = tissue transglutaminase; IgA = immunoglobulin A; FOBT = fecal occult blood test; CAP = chest/abdomen/pelvis; ACR = American College of Radiology; CEA = carcinoembryonic antigen; CA-125 = cancer antigen 125; UWL = unintentional weight loss; CMP = comprehensive metabolic panel; TSH = thyroid-stimulating hormone; ESR = erythrocyte sedimentation rate; CRP = C-reactive protein; LDH = lactate dehydrogenase; PET = positron emission tomography

Comorbidity Screening

CONDITION	PREVALENCE IN THIS POPULATION	SCREENING APPROACH
Cardiovascular disease (CHF, CAD)	CVD prevalence 75–77% in ages 60–79 and 89–90% in ≥80;[45] limits surgical candidacy and chemo tolerance	Cardiology clearance pre-surgery; ECG + troponin if 5-FU/capecitabine started (cardiotoxicity 2–7.6% with continuous 5-FU infusion);[46] monitor BP closely with bevacizumab (HTN incidence 21–40%);[47] withhold bevacizumab if **proteinuria ≥2 g/24 hr**[47]
Diabetes mellitus	T2D associated with CRC risk (RR 1.38 colon, 1.20 rectal);[48] HR 1.47 in SCCS prospective cohort;[49] reach CRC screening-level risk **4–5 years earlier than general population**[50]	A1c target ~7% during adjuvant therapy (**individualize in frail patients**);[51] monitor glucose closely during capecitabine/5-FU; DM affects surgical healing and chemotherapy tolerance

ABBREVIATIONS: CVD = cardiovascular disease; CHF = congestive heart failure; CAD = coronary artery disease; ECG = electrocardiogram; 5-FU = 5-fluorouracil; BP = blood pressure; HTN = hypertension; T2D = type 2 diabetes mellitus; CRC = colorectal cancer; RR = relative risk; SCCS = Southern Community Cohort Study; HR = hazard ratio; DM = diabetes mellitus; A1c = hemoglobin A1c; CKD = chronic kidney disease; eGFR = estimated glomerular filtration rate; AUC = area under the curve; CrCl = creatinine clearance; COPD = chronic obstructive pulmonary disease; OR = odds ratio; aHR = adjusted hazard ratio; PHQ-9 = Patient Health Questionnaire-9; GAD-7 = Generalized Anxiety Disorder 7-item scale; NCCN = National Comprehensive Cancer Network

CONDITION	PREVALENCE IN THIS POPULATION	SCREENING APPROACH
Chronic kidney disease (CKD)	CKD prevalence ~14% in US adults;[52] eGFR declines with age; limits oxaliplatin and bevacizumab dosing	Baseline eGFR before oxaliplatin; reduce oxaliplatin to 65 mg/m² if CrCl 30 mL/min (AUC ↑342%);[53] monitor proteinuria during bevacizumab; **withhold bevacizumab if proteinuria ≥2 g/24 h**;[47] nephrology co-management if eGFR 45 mL/min
COPD	**OR 1.57** for postoperative pulmonary complications after CRC surgery;[54] aHR 1.26 for 5-year CRC mortality with COPD[54]	Optimize bronchodilator therapy pre-surgery; defer elective surgery during acute exacerbation; pulmonary clearance if moderate-severe COPD; monitor for immune checkpoint pneumonitis if pembrolizumab used
Depression/ Anxiety	Mean prevalence of clinical depression ~21% across all cancers;[55] 12-month prevalence of any mental disorder higher in cancer patients (OR 1.28)[56]	Screen with PHQ-9 and GAD-7 at initial oncology visit and at changes in disease status;[56] NCCN Distress Thermometer score ≥4 triggers clinical assessment;[57] social work referral; survivor care plan includes mental health assessment

ABBREVIATIONS: CVD = cardiovascular disease; CHF = congestive heart failure; CAD = coronary artery disease; ECG = electrocardiogram; 5-FU = 5-fluorouracil; BP = blood pressure; HTN = hypertension; T2D = type 2 diabetes mellitus; CRC = colorectal cancer; RR = relative risk; SCCS = Southern Community Cohort Study; HR = hazard ratio; DM = diabetes mellitus; A1c = hemoglobin A1c; CKD = chronic kidney disease; eGFR = estimated glomerular filtration rate; AUC = area under the curve; CrCl = creatinine clearance; COPD = chronic obstructive pulmonary disease; OR = odds ratio; aHR = adjusted hazard ratio; PHQ-9 = Patient Health Questionnaire-9; GAD-7 = Generalized Anxiety Disorder 7-item scale; NCCN = National Comprehensive Cancer Network

Staging/Severity Matrix

STAGE	TNM	DESCRIPTION	NCCN TREATMENT RISK CATEGORY
0	Tis, N0, M0	Carcinoma in situ (intramucosal; no invasion through muscularis mucosae)	Observation; endoscopic or local excision
I	T1–2, N0, M0	Tumor confined to submucosa (T1) or muscularis propria (T2); no nodal or distant spread	Observation after surgical resection

ABBREVIATIONS: TNM = tumor-node-metastasis; NCCN = National Comprehensive Cancer Network; Tis = carcinoma in situ; T = tumor depth; N = regional lymph node involvement; M = distant metastasis; CAPEOX = capecitabine + oxaliplatin; FOLFOX = leucovorin + 5-fluorouracil + oxaliplatin; CRS = cytoreductive surgery; HIPEC = hyperthermic intraperitoneal chemotherapy

STAGE	TNM	DESCRIPTION	NCCN TREATMENT RISK CATEGORY
IIA	T3, N0, M0	Tumor invades through muscularis propria into pericolorectal tissues; no nodes	Low-risk Stage II (if no high-risk features): observation preferred
IIB	T4a, N0, M0	Tumor penetrates visceral peritoneum (serosa)	High-risk Stage II: consider adjuvant chemotherapy
IIC	T4b, N0, M0	Tumor directly invades or adheres to adjacent organs/structures	High-risk Stage II: adjuvant chemotherapy recommended
IIIA	T1–2, N1/N1c, M0 or T1, N2a, M0	Early T-stage with limited nodal involvement (1–6 nodes) or tumor deposits	Low-risk Stage III: CAPEOX 3 mo or FOLFOX 3–6 mo
IIIB	T3–4a, N1/N1c, M0 or T2–3, N2a, M0 or T1–2, N2b, M0	Intermediate depth with moderate nodal burden	Stratified by specific TNM: low-risk (T1–3/N1) vs. high-risk (T4 or N2)
IIIC	T4a, N2a, M0 or T3–4a, N2b, M0 or T4b, N1–2, M0	Advanced local disease with extensive nodal involvement	High-risk Stage III: CAPEOX 3–6 mo or FOLFOX 6 mo
IVA	Any T, Any N, M1a	Metastasis to one distant site/organ without peritoneal involvement	Systemic therapy ± metastasectomy if resectable
IVB	Any T, Any N, M1b	Metastasis to ≥2 distant sites/organs without peritoneal involvement	Systemic therapy; resectability assessment
IVC	Any T, Any N, M1c	Peritoneal metastasis ± other organ metastases	Systemic therapy; consider CRS/HIPEC in select cases

ABBREVIATIONS: TNM = tumor-node-metastasis; NCCN = National Comprehensive Cancer Network; Tis = carcinoma in situ; T = tumor depth; N = regional lymph node involvement; M = distant metastasis; CAPEOX = capecitabine + oxaliplatin; FOLFOX = leucovorin + 5-fluorouracil + oxaliplatin; CRS = cytoreductive surgery; HIPEC = hyperthermic intraperitoneal chemotherapy

⚠ RED FLAG — RAPID RECURRENCE

Rising CEA during surveillance: Even a **modest upward trend** (e.g., 2.5 → 5.0 → 9.0 ng/mL over consecutive measurements) should prompt CT chest/abdomen/pelvis and oncology consultation **before** the next scheduled interval.[1,2] New neurological symptoms in known CRC patient: Brain metastasis occurs in **~5% of CRC patients** = headache, focal neurologic deficits, or new cognitive change → CT/MRI brain without delay; oncology referral.

3 MEAT DOCUMENTATION ESSENTIALS

72-year-old male Medicare Advantage patient. **Patient initially declined colonoscopy**, opting to perform mail-in FIT. Positive FIT (fecal hemoglobin 180 µg/g) prompted **follow-up diagnostic colonoscopy within 2 mo**, identifying a 3.5 cm sigmoid mass. Pathology: moderately differentiated adenocarcinoma, pT3 N1a M0, AJCC Stage IIIB (8th edition),[58] pMMR/MSS. Completed laparoscopic sigmoid colectomy[13,59] + CAPEOX × 3 months.[2,60] Now 18 months post-surgery in surveillance.

MONITOR: "Diagnosis: Malignant neoplasm of sigmoid colon (C18.7), pT3 N1a M0, AJCC Stage IIIB, pMMR/MSS.[58] CEA 1.8 ng/mL (stable from 1.6 at 3/2026; baseline pre-op 8.2). CT C/A/P (3/2026): negative for recurrence. Last colonoscopy 9/2025: no polyps, no advanced adenoma. CBC: Hgb 14.1 g/dL (stable), platelets 218k. Neuropathy assessment: Grade 1 distal paresthesias, stable since CAPEOX completion. Weight: 178 lbs (stable)."

EVALUATE:"Surgical pathology: 14 of 22 regional nodes examined (adequate; ≥12 required per AJCC/CAP/NCCN).[2] Stage IIIB confirmed; T3, N1a (1 positive node), no LVI/PNI/perforation. Per NCCN COL-4, T1–3/N1 is classified as low-risk Stage III for treatment stratification; CAPEOX × 3 months was appropriate.[2,60] MMR proficient (pMMR/MSS); immunotherapy not indicated.[2] Oxaliplatin-induced peripheral neuropathy (G62.0): Grade 1, non-disabling; duloxetine may be considered for painful neuropathy per NCCN Survivorship; pregabalin/gabapentin not recommended.[2] ECOG performance status: 0. ADLs fully independent."

ASSESS: "Stage IIIB sigmoid adenocarcinoma (C18.7), s/p laparoscopic sigmoid colectomy (9/2024) + CAPEOX × 3 months; currently NED at 18 months. Low-risk Stage III treatment category (T1–3/N1).[2] Oxaliplatin-induced peripheral neuropathy (G62.0), Grade 1, improving. Surveillance on track per NCCN Colon Cancer v1.2026. No evidence of recurrence. IDEA collaboration: 5-year OS 89.6%for low-risk Stage III (3-month arm).[60] PI3K pathway alteration status should be documented; if somatic PI3K pathway alterations present, aspirin 100–162 mg daily × 3 years is recommended (ALASCCA: HR 0.49 for recurrence)."[2,61]

TREAT: "Continue NCCN surveillance per COL-8:[2] next CEA 9/2026 (every 3–6 mo for first 2 y, then every 6 mo for total 5 y); next CT C/A/P 9/2026 (every 6–12 mo for total 5 y); next colonoscopy 9/2026 (1 y post-surgery; if no advanced adenoma, repeat at 3 y, then every 5 y).[2] Aspirin: If somatic PI3K pathway alterations confirmed on molecular profiling, aspirin 100–162 mg PO daily × 3 years (NCCN COL-4);[2,61] separately, NCCN Survivorship recommends considering aspirin 325 mg daily for general secondary CRC prevention regardless of PI3K status.[2] Counseled on surveillance importance, recurrence signs, and lifestyle modifications (≥150 min/wk moderate-vigorous physical activity, plant-based diet, alcohol limitation).[2] Oncology co-management: Dr. [Name]. Follow-up: 3 months or sooner if symptoms develop."

Clinical Documentation Elements

- **Current disease status:** Document as active disease, NED after curative treatment, recurrence, or metastatic; **each state drives different coding**, care coordination, and quality measure implications. CRC must be reassessed by MEAT **every calendar year**
- **Anatomic site:** Specify exact colon segment; sigmoid (C18.7), ascending (C18.2), etc. C18.9 (unspecified site) should be **avoided when anatomy is known**
- **TNM staging and biomarkers:** Include all TNM components with AJCC 8th edition stage group.[58] Note that pT3 N1a M0 = Stage IIIB (not IIIA); Stage IIIA is restricted to T1–2/N1 or T1/

N2a.[58] Document pMMR/MSS status, PI3K pathway alteration status, and any RAS/BRAF/HER2 results; biomarker data is essential for treatment planning and aspirin eligibility[2,61]

- **Surgical procedure**: For sigmoid colon cancer (C18.7), the standard oncologic resection is a sigmoid colectomy with ligation of the inferior mesenteric artery or superior rectal branch, not a left hemicolectomy.[2,34] Left hemicolectomy removes the splenic flexure through the sigmoid and is indicated for descending colon or splenic flexure tumors.[2] The extent of resection should correspond to the lymphovascular drainage of the cancer[34]
- **Treatment phase:** Specify current phase explicitly: active treatment (regimen + cycle + response), adjuvant complete (date), surveillance (schedule dates), or recurrence management. For this patient: adjuvant CAPEOX completed [date], now in active surveillance per NCCN COL-8[2]
- **Active complications:** Oxaliplatin neuropathy (G62.0) — consider duloxetine for painful neuropathy only; pregabalin/gabapentin not recommended per NCCN.[2] Chemotherapy-induced anemia (D64.81), ostomy status (Z93.3) if applicable; each may carry independent HCC or quality implications; list all active comorbidities
- **Surveillance plan:** Document next CEA date, next CT date, next colonoscopy date, and responsible provider.[2] Routine CEA monitoring and CT scanning are not recommended beyond 5 years.[2] Surveillance schedule adherence is the primary quality outcome for CRC in primary care
- **Aspirin for secondary prevention**: NCCN provides two distinct aspirin recommendations: (1) For all stage II–III CRC with somatic PI3K pathway alterations, aspirin 100–162 mg PO daily × 3 years after surgery (ALASCCA trial: HR 0.49 for recurrence with PIK3CA exon 9/20 mutations);[61] For general CRC survivorship, consider daily aspirin 325 mg for secondary prevention.[2] Molecular profiling should be performed on all stage II–III CRC tumors to determine PI3K eligibility[2]

Reframing Common Documentation Shortcuts

INSTEAD OF…	DOCUMENT…
"History of colon cancer"	"Stage IIA ascending colon adenocarcinoma (C18.2), s/p right hemicolectomy 9/2024, **NED**. Surveillance: CEA 1.9 ng/mL stable, CT negative 1/2026, next colonoscopy 1/2027."
"Colon cancer stable"	"Stage IIIB sigmoid adenocarcinoma (C18.7), pT3 N1a M0, NED at 18 months: CEA 1.8 ng/mL (stable), CT negative 3/2026, surveillance on track per NCCN."

ABBREVIATIONS: C18.2 = ICD-10 code for ascending colon; s/p = status post; NED = no evidence of disease; CEA = carcinoembryonic antigen; CT = computed tomography; C18.7 = ICD-10 code for sigmoid colon; pT3 N1a M0 = pathologic TNM staging; NCCN = National Comprehensive Cancer Network; FOLFOX = leucovorin + 5-fluorouracil + oxaliplatin; PCP = primary care physician; BP = blood pressure; G62.0 = ICD-10 code for drug-induced polyneuropathy; CBC = complete blood count; Z93.3 = ICD-10 code for colostomy status; APR = abdominoperineal resection; HCC = hierarchical condition category; CRC = colorectal cancer; CV = cardiovascular

INSTEAD OF…	DOCUMENT…
"Cancer — see oncology"	"Stage IIIB sigmoid adenocarcinoma, on FOLFOX cycle 8/12; co-managed with Dr. [Oncologist]. PCP role: monitoring BP, neuropathy (G62.0), CBC, and medication tolerance."
"Colostomy present"	"**Permanent colostomy (Z93.3)**, s/p APR for stage III low rectal cancer. Functioning, pouch system reviewed, skin intact. Active problem per HCC 463 documentation standard."
"See oncology notes"	"CRC status confirmed from oncology note 3/2026: NED, surveillance on track per shared care plan. PCP actively co-managing neuropathy, CV risk, and surveillance adherence."

ABBREVIATIONS: C18.2 = ICD-10 code for ascending colon; s/p = status post; NED = no evidence of disease; CEA = carcinoembryonic antigen; CT = computed tomography; C18.7 = ICD-10 code for sigmoid colon; pT3 N1a M0 = pathologic TNM staging; NCCN = National Comprehensive Cancer Network; FOLFOX = leucovorin + 5-fluorouracil + oxaliplatin; PCP = primary care physician; BP = blood pressure; G62.0 = ICD-10 code for drug-induced polyneuropathy; CBC = complete blood count; Z93.3 = ICD-10 code for colostomy status; APR = abdominoperineal resection; HCC = hierarchical condition category; CRC = colorectal cancer; CV = cardiovascular

DOCUMENTATION REMINDER: GOOD DOCUMENTATION IS COMPREHENSIVE CODING

Under HCC V28,[4] active malignancy codes (C18.x, C19, C20) map to HCC 22 (RAF 0.363). Site-specific **secondary malignancy codes** (e.g., C78.7 liver, C78.0x lung, C78.6 peritoneum) add HCC 17 (RAF 4.209) or HCC 18 (RAF 2.341) depending on metastatic site. Ostomy status (Z93.2 ileostomy; Z93.3 colostomy) supports HCC 463 independently. Upon completion of curative-intent treatment with no evidence of disease, **codes transition to Z85.038/ Z85.048** (personal history), which carry no RAF weight. Documentation should reflect current disease status, anatomic site, stage, biomarkers, active treatment-related complications (e.g., neuropathy, malnutrition, anemia), and ongoing treatment to support accurate clinical representation and appropriate care coordination resources.

4 TREATMENT & REFERRAL QUICK GUIDE

Therapy Escalation Criteria

TRIGGER	ACTION
Positive stool screening (FIT or mt-sDNA)	Diagnostic colonoscopy referral **ASAP (1-3 mo)**;[13] prioritize earlier colonoscopy for high fecal hemoglobin concentration (≥200 µg/g) and/or symptomatic patients[2,13,34]
Confirmed CRC on biopsy (any stage)	Surgical oncology referral; optimal timing for **curative-intent resection** is 3–6 weeks after diagnosis when neoadjuvant therapy is not planned.[2] Simultaneous **MMR/MSI testing** (universal, all CRC); for metastatic disease, KRAS/NRAS/BRAF/HER2 via MGPT ordered as rapidly as possible; for stage II–III, test for somatic PI3K pathway alterations. DPYD pharmacogenomic testing prior to fluoropyrimidines (FDA Boxed Warning); use should be avoided in patients with homozygous/compound heterozygous variants causing complete DPD deficiency
Stage II–IV diagnosis; adjuvant/systemic therapy consideration	Medical oncology referral (urgent); shared care plan between oncologist and PCP. Stage II–III: CEA every 3–6 months for 2 years, then every 6 months for 5 years total; C/A/P CT every 6–12 months for 5 years. Stage IV: C/A/P CT every 3–6 months × 2 years, then every 6–12 months for 5 years total
Rising CEA during surveillance (serial elevation, even modest trend)	Workup: physical exam, colonoscopy, C/A/P CT with contrast; if CT negative, consider FDG-PET/CT and re-evaluate with CT every 3 months. Do not perform blind CEA-directed laparotomy. Oncology consultation for any positive findings
New bowel obstruction/lower GI hemorrhage	Immediate ED transfer; surgical emergency assessment. For obstruction: CT abdomen/pelvis with IV contrast, NPO, NG decompression, IV fluids; surgical options individualized (one-stage colectomy, resection with diversion, diversion, or stent as bridge to surgery). For hemorrhage: two large-bore IV access, resuscitation, type and crossmatch; exclude upper GI source; CTA if hemodynamically unstable; colonoscopy within 24 hours if stabilized. Document clinical trigger and response per MEAT framework

ABBREVIATIONS: FIT = fecal immunochemical test; mt-sDNA = multi-target stool DNA; CRC = colorectal cancer; MMR = mismatch repair; MSI = microsatellite instability; KRAS = Kirsten rat sarcoma viral oncogene homolog; NRAS = neuroblastoma RAS viral oncogene homolog; BRAF = B-Raf proto-oncogene; HER2 = human epidermal growth factor receptor 2; MGPT = multigene panel testing; PI3K = phosphoinositide 3-kinase; DPYD = dihydropyrimidine dehydrogenase gene; FDA = US Food and Drug Administration; DPD = dihydropyrimidine dehydrogenase; PCP = primary care physician; CEA = carcinoembryonic antigen; C/A/P CT = chest/abdomen/pelvis computed tomography; FDG-PET/CT = fluorodeoxyglucose positron emission tomography/computed tomography; ED = emergency department; IV = intravenous; NPO = nil per os; NG = nasogastric; CTA = computed tomography angiography; GI = gastrointestinal; MEAT = Monitor, Evaluate, Assess/Address, Treat

NCCN Colon Cancer v1.2026 Aligned Recommendations[2]

CATEGORY	RECOMMENDED AGENT/ APPROACH	NOTES
Stage I (T1–2 N0)	Surgical resection (colectomy, ≥12 LN)	Endoscopic resection for **select T1 lesions**; surveillance colonoscopy at 1 yr; no adjuvant chemo
Stage II (low-risk pMMR/MSS)	Surgery → observation	High-risk features (T4, LVI, PNI, perf, obstruct, <12 LN) → consider capecitabine or 5-FU/LV; dMMR/MSI-H → observation preferred
Stage III low-risk (T1–3, N1)	CAPEOX × 3 mo or mFOLFOX6 × 3–6 mo	CAPEOX **preferred in older adults** (oral dosing, fewer visits); DPYD testing mandatory before fluoropyrimidine(1)
Stage III high-risk (T4 or N2)	CAPEOX × 3–6 mo or FOLFOX × 6 mo	dMMR/MSI-H: FOLFOX + atezolizumab or CAPEOX + atezolizumab (new preferred option in NCCN v1.2026)
Stage IV dMMR/ MSI-H	Pembrolizumab first-line (KEYNOTE-177: PFS 16.5 vs 8.2 mo, HR 0.60)	PCP role: regular TFTs, LFTs; monitor for immune AEs — colitis, thyroiditis, hepatitis, pneumonitis
Stage IV pMMR/ MSS	FOLFOX/CAPEOX ± bevacizumab; left-sided: + cetuximab/ panitumumab if RAS/BRAF wild-type	PCP role: monitor BP (bevacizumab), skin rash/Mg^{2+} (anti-EGFR), neuropathy (oxaliplatin)

ABBREVIATIONS: CAPEOX = capecitabine + oxaliplatin; CEA = carcinoembryonic antigen; dMMR = deficient mismatch repair; DPYD = dihydropyrimidine dehydrogenase; EGFR = epidermal growth factor receptor; FOLFOX = leucovorin + 5-FU + oxaliplatin; HR = hazard ratio; LN = lymph nodes; LVI = lymphovascular invasion; Mg^{2+} = magnesium; MSI-H = microsatellite instability-high; NCCN = National Comprehensive Cancer Network; PFS = progression-free survival; PNI = perineural invasion; pMMR = proficient mismatch repair; TFTs = thyroid function tests

Non-Pharmacologic Treatment and Lifestyle Modification

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Physical activity	**≥150 min/week** moderate intensity; strength training 2×/week	Reduces CRC recurrence risk and all-cause cancer mortality 15–25%; resume after acute surgical recovery
Dietary pattern	Plant-based, **high fiber (≥25 g/day)**; limit processed/red meat to <2 servings/week	Associated with RR reduction 0.7–0.9 for CRC; dietitian referral if significant nutritional deficit post-surgery

ABBREVIATIONS: BMI = body mass index; CRC = colorectal cancer; ED = emergency department; HCC = hierarchical condition category; HR = hazard ratio; OR = odds ratio; RR = relative risk

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Weight management	Target **BMI <30**; avoid weight gain during adjuvant therapy	Obesity HR 1.4–1.5 for CRC-related mortality; modest weight loss improves treatment tolerance and outcomes
Alcohol reduction	Limit to **<1 drink/day** or abstinence preferred	Alcohol OR 1.2–1.5 for CRC incidence; liver involvement with metastatic disease makes alcohol particularly harmful
Smoking cessation	Complete cessation; offer pharmacotherapy + behavioral counseling	Smoking associated with worse CRC outcomes, increased recurrence risk, and surgical complications
Ostomy care support	Wound/ostomy nurse referral at diagnosis; review supplies at every visit	Ostomy complications are a leading cause of unplanned ED visits

ABBREVIATIONS: BMI = body mass index; CRC = colorectal cancer; ED = emergency department; HCC = hierarchical condition category; HR = hazard ratio; OR = odds ratio; RR = relative risk

QUALITY OUTCOME - ASPIRIN USE IN CRC

Adjuvant aspirin (100–162 mg daily × 3 years post-surgery) is recommended by the NCCN (v2.2026, category 2A) for stage II–III colon and rectal cancer with **confirmed somatic PI3K pathway alterations** (PIK3CA exon 9/20 mutations, PIK3R1/PTEN variants, or deep PTEN deletions; ~37% of CRC harbor these alterations).[2] The ALASCCA trial (n=626) demonstrated HR 0.49 for recurrence in PIK3CA hotspot mutations and HR 0.42 for broader PI3K alterations, with a meta-analysis of 4 RCTs (n=789) showing pooled DFS HR 0.65 (95% CI 0.46–0.90).[62]

Aspirin may be initiated concurrent with adjuvant chemotherapy; confirm with oncology before starting and **assess bleeding risk** (ALASCCA: severe AEs 16.8% vs. 11.6% placebo; contraindicated with active GI bleeding, anticoagulant use, or aspirin allergy).[62] For Lynch syndrome, **daily aspirin is separately recommended** based on the CAPP2 trial (per-protocol HR 0.56 for CRC incidence; NNT 24), with dose individualized per bleeding risk.[2] For **primary prevention** in the general population, evidence is unclear; a 2026 Cochrane review[63] (8 RCTs, n=97,567) found no CRC incidence reduction at 15 years and high-certainty evidence of increased serious hemorrhage (RR 1.59); aspirin is not recommended for CRC prevention alone but **may be considered in patients aged ≤70 with ≥10% 10-year CVD risk** as a cardiovascular decision with potential CRC co-benefit per AGA guidance.[2]

Medication Safety and Dose Adjustments

DRUG/CLASS	INTERACTION/CONTRAINDICATION	CLINICAL ACTION
Oxaliplatin[2,53]	Cumulative peripheral sensory neuropathy is **dose-limiting**. Reduce to 75 mg/m² (adjuvant) or 65 mg/m² (advanced) for persistent Grade 2; discontinue for persistent Grade 3 or any Grade 4. Initial dose 65 mg/m² if CrCl 30 mL/min. Strongly consider **discontinuation after 3–4 months of therapy**	Neurologic assessment before each cycle. Delay next dose until ANC ≥1.5×10⁹/L and platelets ≥75×10⁹/L. Oxaliplatin may be reintroduced if stopped for neurotoxicity rather than progression
Capecitabine/5-FU[64,65]	FDA Boxed Warning: **test for DPYD variants** prior to initiation unless immediate treatment is necessary. Avoid use in patients with homozygous/compound heterozygous variants causing **complete DPD deficiency**. 4–8% of population carries deleterious variants. Potentiates warfarin (monitor INR). PPE (hand-foot syndrome) is common	DPYD testing before first dose; dose-reduce for Grade 2+ PPE; if DPYD variant detected, reduce starting dose per CPIC guidelines with planned dose escalation if tolerated. Close INR monitoring if on warfarin
Bevacizumab[2,66]	Hypertension (Grade 3–4 in 5-18%); proteinuria (24% all-grade); GI perforation (0.3%–3%); arterial thromboembolism; impaired wound healing. **Withhold for severe uncontrolled HTN**; discontinue for hypertensive crisis, nephrotic syndrome, Grade 3–4 hemorrhage, or severe ATE	Monitor BP every 2–3 weeks during treatment. Withhold if proteinuria ≥2 g/24 h; resume when 2 g. Hold ≥6 weeks before and 6–8 weeks after elective surgery. **Increased stroke risk in patients ≥65 years**
Cetuximab/ Panitumumab (anti-EGFR) [67,68]	Restricted to KRAS/NRAS/BRAF **wild-type**, left-sided tumors only. **Acneiform rash** (most common AE); hypomagnesemia (higher in elderly on panitumumab); infusion reactions (more frequent with cetuximab due to chimeric structure); 49% increased risk of high-grade infections	RAS/BRAF/KRAS testing required before use; monitor Mg^{2+} with each cycle; skin care protocol; premedicate for infusion reactions

ABBREVIATIONS: 5-FU = 5-fluorouracil; AE = adverse event; ANC = absolute neutrophil count; ATE = arterial thromboembolism; BP = blood pressure; CPIC = Clinical Pharmacogenetics Implementation Consortium; CrCl = creatinine clearance; CRC = colorectal cancer; dMMR = deficient mismatch repair; DPD = dihydropyrimidine dehydrogenase; DPYD = dihydropyrimidine dehydrogenase gene; EGFR = epidermal growth factor receptor; FDA = U.S. Food and Drug Administration; GI = gastrointestinal; HTN = hypertension; INR = international normalized ratio; irAE = immune-related adverse event; MSI-H = microsatellite instability-high; PPE = palmar-plantar erythrodysesthesia; TB = tuberculosis

DRUG/CLASS	INTERACTION/CONTRAINDICATION	CLINICAL ACTION
Pembrolizumab/ Nivolumab (checkpoint) [69–71]	For dMMR/MSI-H CRC only. Immune-mediated AEs: colitis (3%), hepatitis (3%), thyroiditis, pneumonitis, adrenal insufficiency. Grade ≥3 irAEs in ~9% with monotherapy; treatment discontinuation ~7%. Screen for HBV and latent TB before initiation	TSH/FT4 every 4–6 weeks; CBC and CMP before each cycle or every 4 weeks; GI symptom monitoring each visit. Hold drug and initiate corticosteroids (1–2 mg/kg) for Grade ≥3 irAEs. Consider infliximab or vedolizumab for steroid-refractory colitis. Consider discontinuation after 2 years if disease response

ABBREVIATIONS: 5-FU = 5-fluorouracil; AE = adverse event; ANC = absolute neutrophil count; ATE = arterial thromboembolism; BP = blood pressure; CPIC = Clinical Pharmacogenetics Implementation Consortium; CrCl = creatinine clearance; CRC = colorectal cancer; dMMR = deficient mismatch repair; DPD = dihydropyrimidine dehydrogenase; DPYD = dihydropyrimidine dehydrogenase gene; EGFR = epidermal growth factor receptor; FDA = U.S. Food and Drug Administration; GI = gastrointestinal; HTN = hypertension; INR = international normalized ratio; irAE = immune-related adverse event; MSI-H = microsatellite instability-high; PPE = palmar-plantar erythrodysesthesia; TB = tuberculosis

When to Refer

CRITERION	SPECIALIST	URGENCY
Positive FIT; red-flag symptoms; suspected CRC	Gastroenterology	Urgent (≤1-3 mo)
Confirmed CRC requiring resection (any stage)	Surgical Oncology	Urgent (3-6 wks)
Stage III–IV: adjuvant/systemic therapy planning	Medical Oncology	Urgent (<2 wks)
dMMR/MSI-H result; suspected Lynch syndrome; FHx FDR <50	Genetics/Genetic Counseling	Prompt (4–6 wks)
Permanent ostomy; ostomy complications	Wound/Ostomy Nurse + Colorectal Surgery	Routine (1-6 wks post-discharge)

ABBREVIATIONS: CRC = colorectal cancer; dMMR = deficient mismatch repair; FDR = first-degree relative; FHx = family history; FIT = fecal immunochemical test; MSI-H = microsatellite instability-high

Follow-Up Timing

STAGE/ CATEGORY	FREQUENCY	LABS TO MONITOR
Stage I[2]	**Colonoscopy-only surveillance**; no routine scheduled H&P, CEA, or CT. Imaging only if symptomatic or clinical concern for recurrence	Colonoscopy at 1 yr post-surgery; if no advanced adenoma, repeat at 3 yr, then every 5 yr
Stage II-III[2,72]	H&P every 3–6 mo × 2 yr, then every 6 mo for total of 5 yr	CEA every 3–6 mo × 2 yr, then every 6 mo for total of 5 yr (if candidate for further intervention. C/A/P CT every 6–12 mo for total of 5 yr (category 2B for frequency 12 mo). Colonoscopy at 1 yr; if no advanced adenoma, repeat at 3 yr, then every 5 yr. FDG-PET/CT not indicated. ctDNA not recommended
Stage IV (resected, NED) [2,72]	H&P every 3–6 mo × 2 yr, then every 6 mo for total of 5 yr	CEA every 3–6 mo × 2 yr, then every 6 mo for total of 5 yr. C/A/P CT every 3–6 mo × 2 yr (category 2B for 6 mo), then every 6–12 mo for total of 5 yr . Colonoscopy at 1 yr; same adenoma-based schedule. FDG-PET/CT not indicated
Beyond 5 yr[2,72]	Transition to PCP-led survivorship care	Routine CEA and CT not recommended beyond 5 yr. Continue colonoscopy per adenoma-based intervals

ABBREVIATIONS: C/A/P = chest/abdomen/pelvis; CEA = carcinoembryonic antigen; CT = computed tomography; ctDNA = circulating tumor DNA; FDG = fluorodeoxyglucose; H&P = history and physical examination; NED = no evidence of disease; PCP = primary care physician; PET = positron emission tomography

Comorbidity Management

COMORBIDITY	APPROACH	CAUTION
CVD (CAD, heart failure) [2,47,53]	Cardio-oncology assessment **before initiating cardiotoxic agents**. ECG + baseline troponin if 5-FU/capecitabine planned; coronary vasospasm occurs in 1%–9% of patients, typically within 72 hrs of first cycle. BP monitoring every 2–3 weeks with bevacizumab	5-FU/capecitabine: hold immediately with chest pain; treat vasospasm with CCBs and nitrates. Bevacizumab: withhold if SBP ≥160 or DBP ≥100; discontinue for hypertensive crisis. Increased arterial thromboembolic risk in patients ≥65 years

ABBREVIATIONS: A1c = hemoglobin A1c; AUC = area under the curve; BP = blood pressure; CAD = coronary artery disease; CCB = calcium channel blocker; CKD = chronic kidney disease; COPD = chronic obstructive pulmonary disease; CrCl = creatinine clearance; CVD = cardiovascular disease; DBP = diastolic blood pressure; ECG = electrocardiogram; GAD-7 = Generalized Anxiety Disorder 7-item scale; GFR = glomerular filtration rate; INR = international normalized ratio; KDIGO = Kidney Disease: Improving Global Outcomes; MDD = major depressive disorder; PFTs = pulmonary function tests; PHQ-9 = Patient Health Questionnaire-9; SBP = systolic blood pressure

COMORBIDITY	APPROACH	CAUTION
Diabetes mellitus[71]	**Optimize A1c 8%** during adjuvant therapy. Monitor glucose closely with corticosteroid-containing antiemetic regimens and during fluoropyrimidine therapy. Insulin dose adjustments may be needed during active chemotherapy	Capecitabine **potentiates warfarin** (monitor INR closely). Dexamethasone in antiemetic regimens causes significant hyperglycemia. Coordinate with endocrinology if insulin-dependent or poorly controlled
CKD[47]	Baseline CrCl before oxaliplatin; no dose reduction needed for CrCl ≥30 mL/min. Reduce oxaliplatin starting dose to 65 mg/m² for CrCl 30 mL/min. **Bevacizumab**: withhold if proteinuria **≥2 g/24 hr**; resume when 2 g/24 hr. Nephrology co-management for CrCl 30 mL/min during systemic therapy	Platinum AUC increases 342% in severe renal impairment. **Capecitabine**: contraindicated if CrCl 30 mL/min. eGFR-adjusted dosing required for all renally cleared agents per KDIGO
COPD[73,74]	Optimize **bronchodilator therapy** before surgery; defer elective surgery during acute exacerbation. Spirometry may be considered selectively in symptomatic COPD patients **undergoing abdominal surgery** but is not routinely recommended. Postoperative incentive spirometry and early mobilization reduce pulmonary complications	Routine preoperative PFTs do not add incremental value beyond clinical assessment for non-thoracic surgery. **Checkpoint inhibitor pneumonitis** occurs in ~2.7% (all-grade) with PD-1 monotherapy; monitor O_2 saturation and respiratory symptoms at each visit
Depression/ Anxiety[75–77]	Screen with validated tools (**PHQ-9, GAD-7**) at diagnosis, transitions in care, and at clinically meaningful intervals per NCCN. PHQ-9 **cutoff ≥8** provides 93% sensitivity for **MDD** in cancer patients. Refer to psycho-oncology, social work, or psychiatry as indicated	Distress is an independent predictor of treatment adherence and survival outcomes; suicide risk in cancer patients is approximately **twice the general population** rate. Document screening and interventions in survivorship care plan

ABBREVIATIONS: A1c = hemoglobin A1c; AUC = area under the curve; BP = blood pressure; CAD = coronary artery disease; CCB = calcium channel blocker; CKD = chronic kidney disease; COPD = chronic obstructive pulmonary disease; CrCl = creatinine clearance; CVD = cardiovascular disease; DBP = diastolic blood pressure; ECG = electrocardiogram; GAD-7 = Generalized Anxiety Disorder 7-item scale; GFR = glomerular filtration rate; INR = international normalized ratio; KDIGO = Kidney Disease: Improving Global Outcomes; MDD = major depressive disorder; PFTs = pulmonary function tests; PHQ-9 = Patient Health Questionnaire-9; SBP = systolic blood pressure

Cost-Smart Options

BRAND (EST. COST)	GENERIC/ ALTERNATIVE (EST. COST)	EST. MONTHLY SAVINGS	COST-SMART TIP
Cologuard (mt-sDNA) ~$600/test	FIT (~$20–25/kit, G0328)	~$575/test	FIT preferred over Cologuard at program level for average-risk adults; similar diagnostic yield; comparable adherence with mailed FIT + navigation
Capecitabine brand (Xeloda ~$2,650/mo)	Generic capecitabine (~$31–55/mo)	~$2,600/mo	Generic bioequivalent available since 2013; confirm formulary and payer authorization; DPYD testing before either form
Bevacizumab (Avastin ~$3,900–7,800/cycle)	Bevacizumab biosimilar (Mvasi, Zirabev) ~$3,000–6,000/cycle	~$900–1,800/ cycle	FDA-approved biosimilars available; confirm payer prior authorization pathway; clinical equivalence established

ABBREVIATIONS: DPYD = dihydropyrimidine dehydrogenase gene; FIT = fecal immunochemical test; IV = intravenous; mo = month; mt-sDNA = multi-target stool DNA

Patient Education and Adherence

DOCUMENTATION REMINDER: GOOD DOCUMENTATION IS COMPREHENSIVE CODING

Document patient education provided: topics covered should include current disease status (active/NED/recurrence), surveillance schedule rationale, recurrence recognition signs (weight loss, bleeding, bowel change, new pain), lifestyle recommendations (activity, dietary fiber, **aspirin if PI3K+**), and ostomy care if applicable. **Example language**: "Patient education provided on CRC surveillance: CEA trend monitoring, colonoscopy schedule, recurrence signs (weight loss, bleeding, bowel changes, unexplained pain). Lifestyle counseling: ≥150 min/ week activity, dietary fiber goals. Patient verbalized understanding. Return precautions reviewed. Oncology co-management confirmed."

Quality Metrics Tie-In

2026 MEASURE	STANDARD	NOTES
HEDIS COL (C02): Colorectal Cancer Screening	Ages 45–75 with continuous enrollment (≤1 gap of ≤45 days). **Eligible tests**: colonoscopy (q10y), flexible sigmoidoscopy (q5y), CTC (q5y), mt-sDNA (q3y), FOBT (annual), FIT (annual)	Core Part C Star Rating measure; cut points recalculated annually by CMS clustering methodology (no fixed threshold). **Exclusions**: prior total colectomy or CRC, hospice, palliative care, age ≥66 in institutional SNP or long-term care >90 days, frailty + advanced illness or dementia medication. Highest-impact quality lever for most MA plans due to **large eligible denominator**
MIPS #113: Colorectal Cancer Screening	**Denominator**: Ages 45–75 with qualifying visit during performance period. Same eligible tests and lookback periods as HEDIS COL. **Numerator**: screening results documented and reviewed (CPT 3017F)	Available only for MIPS Value Pathways (MVP) reporting; not available for traditional MIPS reporting. Telehealth encounters are allowable. Same exclusions as HEDIS COL plus frailty/advanced illness/dementia medication exclusions for age ≥66
MIPS #320: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	**Denominator**: Ages 45–75 with screening colonoscopy without biopsy or polypectomy. **Numerator**: 10-year follow-up (±6-month window) interval documented in colonoscopy report and communicated to patient (M1377)	High-priority process measure (NQF 0658); registry-only. Incomplete procedures (modifiers 52, 53, 73, 74) excluded. **Denominator exception**: inadequate bowel prep, personal/family polyp history, age ≥66 with no adenoma, or life expectancy 10 yrs. Only 36.7–39.2% of colonoscopy reports had guideline-concordant interval recommendations in baseline studies
MIPS #451: RAS Gene Mutation Testing Before Anti-EGFR Therapy	**Denominator**: 100% of adults with mCRC receiving anti-EGFR MoAb (cetuximab or panitumumab). **Numerator**: patients with RAS testing before initiation. **Testing**: KRAS and NRAS codons 12/13 (exon 2), 59/61 (exon 3), 117/146 (exon 4)	Registry-only, process measure (NQF 1859). Requires **≥2 encounters during performance period** (not same day). Real-world KRAS testing rates 90–98% in community oncology (2015–2024); NRAS testing rose from 3.8% to 75.3% over same period. NCCN recommends MGPT for all mCRC at initial diagnosis

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; COL = colorectal cancer screening; CRC = colorectal cancer; CTC = computed tomography colonography; EGFR = epidermal growth factor receptor; FIT = fecal immunochemical test; FOBT = fecal occult blood test; HEDIS = Healthcare Effectiveness Data and Information Set; MA = Medicare Advantage; mCRC = metastatic colorectal cancer; MGPT = multigene panel testing; MIPS = Merit-based Incentive Payment System; MoAb = monoclonal antibody; mt-sDNA = multi-target stool DNA; MVP = MIPS Value Pathways; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; SNP = Special Needs Plan

QUALITY METRIC: EMERGING PROCESS MEASURES FOR CRC

NCQA is advancing a new HEDIS measure, "**Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test"**,[78] developed in partnership with the Council of Medical Specialty Societies (CMSS) and the American Gastroenterological Association (AGA), with CDC funding. The measure completed public comment in March 2026 and may be implemented as early as **measurement year 2027**.

This measure directly addresses a critical gap in the screening-to-diagnosis continuum: nationally, an estimated **20–30%** of patients with a positive stool-based screening test **never receive follow-up colonoscopy**, and delays beyond 9–12 months are associated with significantly higher rates of advanced-stage CRC at diagnosis and increased CRC-specific mortality.[79,80]

By measuring the proportion of patients who complete diagnostic colonoscopy after a positive non-invasive screening result, this proposed measure shifts the quality focus from screening initiation (captured by existing **HEDIS COL**) to diagnostic completion, aligning with the principle that screening without timely follow-up confers no survival benefit.

For value-based care programs, this measure would create accountability for the operational infrastructure (patient navigation, closed-loop referral tracking, barrier reduction) needed to ensure that positive screens translate into **early-stage cancer detection** and curative-intent treatment.

5 CODING REMINDERS AND CASE EXAMPLES

Documentation Specificity

- **Anatomic site:** Always document the **specific colon segment** — **C18.2** (ascending), **C18.7** (sigmoid), C19 (rectosigmoid), C20 (rectum); C18.9 (unspecified colon) should be used only when **anatomy is genuinely unknown**
- **Active vs. personal history:** Active malignancy codes (C18.x–C20) apply **during treatment AND active surveillance** when disease may recur. Transition to **Z85.038/**

Z85.048 only when oncology explicitly confirms treatment complete with **NED**. Failure to accurately code has HCC and clinical continuity implications

- **Metastatic sites:** Code each active metastatic site separately: **C78.7** (liver → HCC 17), **C78.0x** (lung → HCC 17), **C79.51** (bone → HCC 18). Each contributes independently to the clinical and risk picture
- **Staging and biomarkers:** Document AJCC TNM stage (8th edition) with all T/N/M components. Record **pMMR/MSS** or **dMMR/MSI-H** status; include RAS/BRAF/HER2 results when available — these drive treatment selection and continuity of care
- **Ostomy status: Z93.3** (colostomy) or **Z93.4** (ileostomy) → HCC 463. Maintain as active problem list entry at every visit, not a historical finding. Include in MEAT with active management evidence (pouch review, skin assessment)
- **Treatment complications:** Oxaliplatin peripheral neuropathy (**G62.0**), chemotherapy-induced anemia (**D64.81**), malnutrition (**E41/E44**); each may carry independent HCC or quality implications when documented with clinical evidence

Annual Clinical Review and Confirmation

- **Annual review:** CRC must be reassessed once per calendar year — **face-to-face or synchronous audio-video encounter** with MEAT documented by 12/31. Confirm current disease status: active, NED, recurrent, or metastatic
- **Visit modality:** In-person or video telehealth qualifies when it supports meaningful evaluation of disease status, labs, and imaging. Document which modality was used and confirm all surveillance intervals reviewed
- **Clinical context:** Under HCC V28, active malignancy (**HCC 22**, RAF 0.363) captures the primary risk weight. Metastatic codes add **HCC 17** (RAF 4.209)/**HCC 18** (RAF 2.341). Ostomy (**HCC 463**) is a separate, independent capture, never rollover without active documentation
- **Biomarker update:** If MMR/MSI, RAS/BRAF, or HER2 status is not yet documented, order and record at next available visit = **essential for treatment planning continuity**, especially if recurrence is detected
- **Avoid rollover:** Do not copy forward "history of colon cancer" without reassessing current disease status. Static labeling removes clinical visibility and may trigger inappropriate code transitions from C18.x to Z85.x

Good Documentation is Comprehensive Coding

EHR SHORTCUT/ RISK	PREFERRED DOCUMENTATION LANGUAGE
"History of colon cancer"	"Stage IIA ascending colon adenocarcinoma (**C18.2**), s/p right hemicolectomy 9/2024, NED. CEA 1.9 ng/mL stable; CT negative 1/2026; colonoscopy 9/2025 clear. Surveillance on track."
"Colon cancer stable"	"Stage IIIA sigmoid adenocarcinoma (**C18.7**), NED at 18 months: CEA 1.8 ng/mL (stable), CT C/A/P negative 3/2026. Next surveillance: CEA + CT 9/2026."
"Metastatic cancer on chemo"	"Stage IV sigmoid adenocarcinoma (**C18.7**) with hepatic metastases (**C78.7**); KRAS wild-type, pMMR/MSS. Bevacizumab + FOLFOX cycle 4/12. BP controlled. Co-managed with oncology."
"Colostomy present"	"Permanent end-colostomy (**Z93.3**) for stage III rectal cancer — functioning, pouch system and skin reviewed, no complications. Active problem; part of annual HCC documentation."
"See oncology for details"	"PCP co-management: CRC stage IIIA, NED per oncology note 3/2026. PCP managing: neuropathy (**G62.0**), hypertension, glycemic control, and surveillance schedule adherence."

ABBREVIATIONS: BP = blood pressure; CEA = carcinoembryonic antigen; CRC = colorectal cancer; CT = computed tomography; FOLFOX = leucovorin + 5-FU + oxaliplatin; HCC = hierarchical condition category; KRAS = Kirsten rat sarcoma viral oncogene; MEAT = Monitor, Evaluate, Assess, Treat; NED = no evidence of disease; pMMR = proficient mismatch repair

EHR Workflow Tips

SMARTPHRASE

.CRC_VISIT auto-populates: Current disease status (active/NED/recurrent) → Anatomic site (C18.x) → AJCC TNM stage → Biomarkers (pMMR/MSS, RAS/BRAF/HER2) → Treatment phase (active regimen, cycle, or surveillance) → Surveillance schedule (next CEA, CT, colonoscopy dates) → Active complications (G62.0, D64.81, Z93.3) → Co-management plan with oncologist name and last contact date. Review disease status before signing — confirm active vs. NED vs. recurrence.

SMARTPHRASE	**.CRC_MEAT** pre-structures all four MEAT elements: **MONITOR** (current CEA with date/trend, CT date, colonoscopy date, weight, labs, neuropathy grade); **EVALUATE** (oncology note review, ECOG performance status, ostomy exam if applicable, complication assessment); **ASSESS** (ICD-10 codes with site + stage + status, active complications with codes, surveillance trajectory); **TREAT** (surveillance plan with explicit dates, referrals, lifestyle counseling, medications).
ALERT	Configure **Surveillance Gap BPA**: Active C18.x in problem list without CEA result in past 6 months → alert fires at scheduling: "CRC Surveillance Gap — CEA overdue. Review NCCN schedule." Configure second BPA: positive FIT result without colonoscopy completion within 180 days → "FIT Follow-Up Gap — Colonoscopy not completed within 6 months of positive test."(5,9,24)
ORDER SET	**CRC Surveillance Order Set** by stage: Stage I–II → CEA, CBC, metabolic panel + colonoscopy order at 1 yr post-surgery; Stage III → CEA q3 mo, CT C/A/P q6 mo + colonoscopy at 1 yr; Stage IV → CEA, CBC, CMP per oncology cycle. Frequency auto-prompts from the most recent stage documented in the problem list.
PROBLEM LIST	Maintain **C18.x, Z93.3, G62.0, D64.81** as active problem list entries at every relevant visit. Do not archive Z93.3 (colostomy) or treatment complications — active problem status is required for HCC 463 capture. Request survivorship care plan from oncology after completion of adjuvant therapy; link to CRC problem list entry.
REFERRAL	**Cancer Registry Integration**: Confirm TNM staging, biomarker profile, and treatment summary are synchronized between oncology EHR and PCP records. Set a recurring reminder at 12 months post-treatment to request an updated survivorship care plan. Use registry integration to flag patients overdue for surveillance (CEA, CT, colonoscopy) who have not appeared for their scheduled visit.

Brief Case Examples

✓ SUCCESS — COMPLETE DISEASE STATUS DOCUMENTATION

SCENARIO

72-year-old male, sigmoid colon adenocarcinoma pT3 N1a M0 (Stage IIIA, pMMR/MSS), s/p laparoscopic left hemicolectomy 9/2024 + CAPEOX × 3 months. Now 18 months post-surgery.

"Stage IIIA sigmoid adenocarcinoma (C18.7), NED at 18 months. CEA 1.8 ng/mL stable (3/2026). CT C/A/P negative 3/2026. Colonoscopy 9/2025: no polyps. Oxaliplatin-induced neuropathy (G62.0), Grade 1, improving. Surveillance on track per NCCN Colon Cancer v1.2026. Next: CEA + CT + colonoscopy 9/2026."

→ HCC 22 (C18.7 during active surveillance, RAF 0.363) + RxHCC 158 (G62.0 neuropathy). Documentation reflects: site-specific code, AJCC stage, current disease status (NED), biomarker status, treatment completion date, active complication with code, and complete surveillance schedule. Satisfies all MEAT elements. Clinical complexity accurately represented to the full care team.

⚠ PITFALL — STATIC LABEL WITH MISSING SPECIFICITY

SCENARIO

Same 72-year-old patient. Documentation: "History of colon cancer, stable; continue follow-up per oncology."

Pitfall: No anatomic site documented. No current disease status (NED not stated). No stage. No biomarker status. Neuropathy (G62.0) not coded. No surveillance schedule documented. No co-management plan. "History of colon cancer" implies Z85.038 — but the patient is in active surveillance (C18.7 is still appropriate).

If Z85.038 coded → HCC not supported(personal history has no RAF). Neuropathy (G62.0) invisible — missed complication. No surveillance dates → gaps invisible to the care team and population health dashboard. No MEAT elements satisfied.Fix: "Stage IIIA sigmoid adenocarcinoma (C18.7), s/p left hemicolectomy 9/2024, NED. Oxaliplatin neuropathy (G62.0), Grade 1. CEA 1.8 ng/mL stable. Next: CEA + CT + colonoscopy 9/2026. Co-managed with oncology." → Restores HCC 22 + complication codes. Full clinical picture documented for all care team members.

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