



AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Colorectal Cancer Screening Quick Reference Guide

2026

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KEY TAKEAWAYS

STARS PERFORMANCE IMPACT

COL is a HEDIS process measure in the Staying Healthy domain with one of the largest eligible denominators in the Medicare Part C Star Ratings program. A single percentage-point improvement across the eligible population can shift Star Rating projections. Plans achieving 4+ Stars receive a 5% quality bonus payment on their benchmark.

1 COL is a high-impact Stars measure

One of the largest eligible populations in Medicare Advantage; even 1% improvement can shift Star Ratings and unlock Quality Bonus Payments (≥ 4 Stars = ~5% revenue increase)

2 Eligible population is broad and growing

Adults aged **45-75**, continuously enrolled (≤ 45 -day gap), creating a large numerator-denominator gap and opportunity for improvement

3 Colonoscopy is the gold standard

Only modality that provides **screening, diagnosis, and polypectomy in one step**, preventing cancer rather than just detecting it

4 Other modalities are two-step pathways

FIT, FOBT, stool DNA, sigmoidoscopy, and CT colonography require **follow-up colonoscopy if positive**, introducing risk of delay and care gaps

5 Closing the gap requires completed screening, not intent

Orders, referrals, or Z12.11 coding **do not count**—screening must be **completed and documented** to meet HEDIS numerator criteria

6 Closed-loop care is essential

Every patient must be tracked from **identification → test completion → results → follow-up**, especially after abnormal non-invasive tests

7 Documentation drives performance

The most common failure is **missing or incomplete documentation**, not lack of screening—capture modality, date, and results in structured fields

8 Colonoscopy follow-up is a major failure point

A substantial proportion of patients with positive stool-based tests **never complete follow-up colonoscopy**, directly impacting outcomes and Stars performance

9 Access and outreach strategies must be targeted

Use **ACS partnerships, freestanding centers, mobile services, and mailed FIT** selectively to reach underserved patients, while maintaining colonoscopy-first intent

10 Early detection improves outcomes and reduces cost

Screening shifts diagnosis to earlier stages, where survival approaches **~90% vs ~13-16% for metastatic disease**, while avoiding high downstream treatment costs

1 MEASURE SNAPSHOT

Measure Identification

The HEDIS Colorectal Cancer Screening (COL) measure assesses the **percentage of members aged 45-75 who had appropriate screening for colorectal cancer**.¹ Colorectal cancer is the **third most commonly diagnosed cancer** in the United States and a leading cause of cancer-related death, yet it is **highly treatable and often curable** when detected at an early or precancerous stage through routine screening. The HEDIS COL measure is developed and maintained by the National Committee for Quality Assurance (**NCQA**), which aligns its specifications with evidence-based clinical guidelines, including recommendations from the U.S. Preventive Services Task Force (**USPSTF**),² the American College of Gastroenterology (**ACG**), and the American Cancer Society (**ACS**), translating those recommendations into **standardized, measurable screening criteria** and intervals for quality reporting. The measure is incorporated into the CMS Medicare Advantage Part C Star Ratings program. In CMS Technical Notes,³ it is identified as **Colorectal Cancer Screening (COL; C02)** and is placed within Domain 1: Staying Healthy: Screenings, Tests, and Vaccines. COL is a CMS process measure, and for the 2026 Star Ratings (based on measurement year 2024 data), it is **single-weighted (weight = 1)** under the CMS weighting methodology. Star Ratings are based on data from **two years prior**, while current-year Star weightings are used to **guide priorities for the active measurement year**.

MEASURE ELEMENT	DETAIL
HEDIS Measure Name	C02 - Colorectal Cancer Screening (COL)
Star Ratings Domain	Staying Healthy: Screenings, Tests, and Vaccines
Measure Type	HEDIS Process Measure
Measure Weight	1x (single weighted) ⁴

MEASURE ELEMENT	DETAIL
Data Sources	Administrative claims + supplemental data + hybrid (chart review)
Eligible Population	Members aged 45–75, continuously enrolled, ≤45-day gap
Test Reporting Timeline	January 1st through December 31st



AAVBC PERSPECTIVE

Achieving success in the HEDIS COL measure requires accurate documentation and a closed-loop care system that ensures eligible patients are identified, educated, and complete screening with timely result reporting. While multiple modalities contribute to performance, colonoscopy remains the gold standard due to its ability to detect and remove precancerous lesions. From a value-based perspective, **site of service matters**; when appropriate, performing colonoscopy in **Ambulatory Surgery Centers (ASCs)** rather than hospital outpatient settings can reduce costs while maintaining high-quality outcomes.

Eligible Population

The HEDIS COL screening measure assesses the percentage of Medicare and Medicaid members aged 45–75 who are continuously enrolled (≤1 gap of up to 45 days) and who had appropriate screening for colorectal cancer with any of the following tests: colonoscopy (**every 10 years**), flexible sigmoidoscopy (**every 5 years**), computed tomography colonography (**every 5 years**), stool DNA test (**every 3 years**), fecal occult blood test (**FOBT; annual**), or fecal immunochemical test (**FIT; annual**).

Exclusion Criteria

The AAVBC emphasizes the importance of accurate and complete documentation within the medical record using **appropriate CPT and ICD-10 codes** to identify eligible exclusions. Proper documentation ensures that patients who meet exclusion criteria are **correctly removed from the COL denominator**, supporting accurate measure reporting and **preventing misclassification** that could negatively impact Star performance.



MAKING CONNECTIONS

For additional **colorectal screening** and **coding information**, please consult the [AAVBC Colorectal Cancer QRG](#).

EXCLUSION CATEGORY	CRITERIA	DOCUMENTATION
Total Colectomy	History of or during measurement year	CPT codes: 44150, 44151, 44152, 44153-44158 ICD-10 codes (Active): 0DTE0ZZ, 0DTE4ZZ, 0DTE3ZZ ICD-10-CCM codes (History): Z90.49
Colorectal Cancer History	History of or during measurement year	CPT codes: any relevant colectomy interventions ICD-10-CM codes (Active): C18.X, C19, C20, C21.0, C21.1, C21.2, C21.8 ICD-10-CM codes (History): Z85.038, Z85.048
Hospice/ Palliative Care	Enrollment during measurement year	HCPCS codes: Q5001-Q5010, G0182 CPT codes: 99377, 99378 ICD-10-CM code: Z51.5 Claims/enrollment data
Frailty + Advanced Illness	Members 66+ meeting HEDIS frailty indicators (≥ 2 on different dates) and advanced illness indicators (≥ 2 encounters or dementia medication); history of or during measurement year	ICD-10 code diagnosis (refer to Section 5); claims; pharmacy data
I-SNP Equivalent Care	Members 66+ in institutional I-SNP equivalent care	Enrollment data; claims; facility records
Deceased	During measurement year	Death records

Star Rating Cut-Points: Insights from MY2024 (2026 Star Ratings)

MY2026 HEDIS performance will inform Star Ratings released in 2028; while current year cut-points are not yet available, **2026 Star Ratings (based on MY2024 data)** provide the most relevant benchmark for current performance strategy. CMS assigns plans an overall **1-5 Star rating** based on aggregated performance across weighted measures, with individual measures such as **Colorectal Cancer Screening (COL; C02)** contributing to domain scores that roll up into the global rating. National colorectal cancer screening (C02) performance is approximately **71%, corresponding to ~3.8 Stars**, indicating that most plans are clustered near the **4-Star threshold**, where small improvements can meaningfully impact ratings.

At the same time, national screening rates ($\sim 63\%$)⁵ remain below the **Healthy People 2030 target ($\sim 74\%$)**, reflecting a persistent numerator-denominator gap driven in part by the

expansion of target screening to ages 45–75. As a high-volume measure, COL is particularly sensitive to incremental gains, making it a **key lever for improving overall Star performance**.

COL STAR RATING	CUT-POINT THRESHOLD (MY2024)	PERFORMANCE CONTEXT
5 Stars	Points $\geq 77\%$	Top-decile national performance
4 Stars	$70\% < \text{Points} < 77\%$	Above-average performance
3 Stars	$60\% < \text{Points} < 70\%$	Average performance
2 Stars	$48\% < \text{Points} < 60\%$	Below-average performance
1 Star	Points $< 48\%$	Lowest-tier performance

Financial Stakes

Plans achieving ≥ 4 Stars in the global CMS 2026 Star Ratings (MY2024) qualify for a **~5% Quality Bonus Payment (QBP)** applied to benchmark revenue, with additional advantages at 5 Stars including year-round enrollment and growth in market share. Even modest improvements in performance can therefore translate into substantial financial impact; for a 50,000-member plan with ~\$12,000 PMPY revenue (~\$600M total), crossing the 4-Star threshold can yield ~\$30M in incremental annual revenue, with further upside from enrollment growth at 5 Stars. Because Star Ratings are based on clustered cut points, small gains in performance can shift plans across thresholds, making **high-volume measures particularly strategic**.

These incentives extend directly to **primary care providers (PCPs) and other care delivery teams**, whose compensation is increasingly tied to quality performance through value-based contracts, shared savings arrangements, and bonus pools linked to Star measures such as COL. High performance can result in enhanced reimbursement, performance bonuses, and preferred network status, while also supporting patient panel growth. Conversely, **low Star performance (≤ 3 Stars)** can have significant consequences, including loss of QBP revenue, reduced benefit competitiveness, declining enrollment, and increased regulatory scrutiny. Plans with sustained low performance may face corrective action plans or even contract termination, with downstream financial pressure often cascading to provider organizations through reduced incentives, tighter utilization controls, and fewer value-based opportunities.

2 SCREENING MODALITIES AND COMPLIANCE WINDOWS

The HEDIS COL measure captures completion of appropriate screening across **multiple accepted modalities**, each with defined compliance windows and documentation requirements that contribute to numerator attainment. While NCQA specifications treat these modalities as equivalent for measure compliance, they differ in clinical function, frequency, and follow-up needs, making accurate documentation and modality selection critical to both quality performance and patient outcomes.

Among these, **colonoscopy remains the gold standard**, as it uniquely combines screening, diagnostic evaluation, and **therapeutic intervention through polypectomy**, enabling the detection and removal of precancerous lesions in a single procedure. This preventive capability distinguishes colonoscopy from other modalities, which rely on subsequent diagnostic follow-up after a positive result and are primarily sensitive to existing, often early-stage cancerous lesions rather than precancerous polyps, and therefore do not independently achieve the same level of cancer prevention.

HEDIS-Accepted Screening Modalities

MODALITY	WINDOW	CLINICAL SETTING*	CPT/HCPCS CODES	TEST PIPELINE**
Colonoscopy	10 years	ASC or hospital outpatient	45378, 45380-45385	One-step (screening + diagnostic + early intervention (polypectomy))
Fecal Immunochemical Test (FIT)	1 year	At-home test; lab-submitted CPT codes	82274 G0328 (HCPCS)	Two-step (positive → colonoscopy)
Fecal Occult Blood Test (FOBT)	1 year	At-home test; lab-submitted CPT codes	82270, 82274	Two-step (positive → colonoscopy)
Multitarget Stool DNA Testing (Cologuard)	3 years	At-home test; lab-submitted CPT codes	81528	Two-step (positive → colonoscopy)
Flexible Sigmoidoscopy	5 years	GI clinic, ASC, or outpatient hospital	45330-45334, 45337, 45338	Two-step (positive → colonoscopy)
CT Colonography	5 years	Free standing imaging center or outpatient hospital	74261, 74262	Two-step (positive → colonoscopy)

*AAVBC strongly supports colonoscopies performed at an ASC (no contraindications such as anaesthesia risk) due to reduced cost, lower nosocomial infection rates, and ability to eliminate precancerous lesions (polypectomy) AAVBC also supports the use of **free standing imaging centers** for CT colonography scans, due to their lower cost compared to outpatient hospitals and lower nosocomial infection rates

Follow-up diagnostic testing for colorectal cancer **does not contribute to the HEDIS COL measure

Numerator/Denominator Specifications

Denominator: Medicare Advantage (MA) enrollees aged 45–75 as of December 31 of the measurement year who meet eligibility criteria per NCQA HEDIS specifications

Numerator: Members in the denominator who completed ≥1 appropriate colorectal cancer screening within the specified lookback period

Goal: Maximize performance by **closing the gap**—ensuring all eligible patients in the denominator are up to date with screening and counted in the numerator

Data Source Rules

DATA SOURCE	DESCRIPTION	OPERATIONAL NOTES
Administrative Claims	Screening CPT/HCPCS codes billed through claims system	Primary capture pathway; watch for diagnostic vs. screening coding errors
Supplemental Data	Provider attestation, HRA, ECDS, state registries	Key for out-of-network and community-based screenings
Hybrid (Chart Review)	Medical record review for members not in claims/supplemental	Resource-intensive; use for targeted gap closure in final months

Emerging: Blood-Based CRC Screening Tests

FDA-approved blood-based tests (e.g., Shield by Guardant Health)⁶ are NOT yet included as qualifying HEDIS COL modalities and thus **can NOT currently be used to close the COL numerator: denominator gap**. CMS has proposed coverage for blood-based biomarker tests every 3 years for Medicare beneficiaries aged 45–85.⁷ Plans should monitor NCQA annual HEDIS updates for potential inclusion. Members screened via blood-based tests will NOT close the COL gap under current specifications.

3 HIGH-YIELD GAP CLOSURE STRATEGIES

Barrier-to-Solution Matrix

BARRIER TYPE	UNDERLYING CAUSES	SOLUTIONS
Breakdown in Closed-Loop Tracking	Incomplete follow-through; patient noncompliance; lack of result tracking, especially after non-invasive tests	Implement closed-loop systems to ensure tests are ordered, completed, results received, and acted upon ; prioritize rapid follow-up colonoscopy after abnormal results; use multichannel communication (phone, mail, patient portal) with patients and caregivers to ensure completion and documentation

BARRIER TYPE	UNDERLYING CAUSES	SOLUTIONS
Insufficient Provider Recommendation/Outreach	Lower screening uptake without recent provider engagement; higher completion when seen within past 18 months	Reinforce colonoscopy-first recommendation during visits; deploy “pit crew” care model with team-based outreach (calls, texts, letters); embed screening prompts into routine visits and pre-visit planning
Access/Structural Barriers	Uninsured status; rural access gaps; transportation limitations; limited access to endoscopy centers	Help patients identify local ACS-supported programs, safety-net providers, or freestanding endoscopy/imaging centers for colonoscopy and CT colonography; leverage mobile or community-based screening services where available; for patients unable to access procedural screening, deploy on-demand mailed FIT programs as an access bridge with clear pathways to follow-up colonoscopy
Procedural Prep Burden/Fear	Colonoscopy preparation, sedation concerns, and invasiveness deter participation	Provide education emphasizing colonoscopy as a one-step diagnostic and therapeutic intervention (polypectomy) with long screening interval; offer navigation support to address prep concerns; use non-invasive tests selectively for patients unwilling to undergo colonoscopy, with clear expectation of follow-up if positive
Health literacy	Limited understanding of CRC risk, screening benefits, and test pathways; language barriers	Deliver culturally tailored education emphasizing preventive value of colonoscopy (early detection and polyp removal); provide multilingual materials; use patient navigation to guide decision-making and completion
Cost concerns	Follow-up colonoscopy cost-sharing	Recent legislation; patient education on \$0 coverage
Age 45-49 awareness gap	Low perceived risk; limited awareness of updated guidelines; low screening uptake (~20%)	Implement targeted outreach emphasizing new eligibility and benefits of early colonoscopy screening; integrate education into primary care visits and digital campaigns
Unapproved HEDIS screening modality used	Use of emerging tests (e.g., blood-based screening) that do not meet HEDIS criteria	Ensure follow-up with HEDIS-approved modalities, prioritizing colonoscopy; use alternative tests only when necessary, with clear documentation and follow-through to diagnostic colonoscopy if indicated

Colonoscopy as the Gold Standard Screening Approach

Colonoscopy should be the **preferred first-line screening modality** for appropriate patients, given its unique ability to function as a **one-step screening, diagnostic, and therapeutic intervention**. Unlike other screening tests, colonoscopy enables **direct visualization of the**

colon and immediate removal of precancerous lesions (polypectomy), thereby preventing cancer development rather than solely detecting existing disease. This preventive capability, combined with a **10-year screening interval**, supports both superior clinical outcomes and reduced long-term healthcare utilization.

While stool-based and other non-invasive tests (e.g., FIT, FOBT, stool DNA) are valuable tools to increase screening uptake, they are **primarily sensitive to existing cancers or advanced lesions** and do not provide the same ability to detect and remove precancerous polyps. In addition, positive results from these tests require **follow-up colonoscopy**, often introducing delays in diagnosis and treatment.

Therefore, colonoscopy should be **preferentially recommended for eligible patients**, particularly those who are able and willing to undergo the procedure. Non-invasive screening options may be appropriate for patients who decline colonoscopy or have contraindications, serving as an **entry point into screening pathways**, with clear expectations for timely follow-up colonoscopy if results are abnormal.

Screening Education and Outreach (Ages 45-49)

Targeted education and outreach programs are critical to improving colorectal cancer screening uptake among adults aged 45–49, a population with persistently low engagement following the 2021 USPSTF guideline update. National data show only **~19.7% to 20% of this group were up to date** with screening shortly after eligibility expansion, with modest improvement to ~22.5% initiation rates in more recent analyses.⁸ Uptake is particularly low among uninsured, low-income, and lower-education populations, reflecting gaps in awareness, access, and perceived risk.^{8,9} Evidence supports multicomponent education and outreach strategies, including culturally tailored messaging, community-based engagement, and proactive provider communication, as effective approaches to increase screening in this cohort.^{10,11} From a value based care perspective, improving **early engagement** in this newly eligible population represents a high-impact opportunity to expand screening coverage, reduce disparities, and **prevent progression to advanced disease** at younger ages.



AAVBC PERSPECTIVE

The AAVBC suggests prioritizing **high-risk patients aged 45-49** (and younger) with a family history of colorectal cancer to be **screened earlier** to identify precancerous or early cancerous lesions to dramatically improve outcomes and lower downstream hospital utilization.

Mailed Screening Kits (FIT, FOBT)

Mailed FIT based outreach is another strategy for value based COL programs because it expands access for members who are **contraindicated for colonoscopy**, overdue for screening, geographically isolated, or less likely to complete office based screening. The ACG identifies FIT as a valuable CRC screening modality,¹² and a 2025 cluster randomized trial in 5,614 rural Medicaid enrollees found that mailed FIT outreach plus navigation produced a 7.3 percentage point increase in CRC screening compared with usual care.¹³ In an underserved urban community health center population, a randomized trial found that serial text messaging plus opt out mailed FIT increased 12 week screening completion from 2.3% to 19.6%, with FIT return rising from 1.4% to 19.1%.¹⁴ Broader meta-analytic evidence supports this approach: stool test outreach was associated with an absolute screening increase of 22% across U.S. trials.¹¹

Reminder and Recall Systems (Closed-Loop Care Approach)

Reminder and recall systems are a core component of a **closed-loop care model**, ensuring that colorectal cancer screening progresses from identification to completion, documentation, and follow-up without gaps. For COL, this means tracking each patient from referral or test order through completion and results reconciliation, with escalation pathways for incomplete steps. Timely reporting of completed tests supports HEDIS Star performance and facilitates early detection, and in the case of colonoscopy, **prevention through removal of precancerous lesions**. While all modalities require closed-loop tracking, **colonoscopy demands the most robust navigation infrastructure** due to procedural complexity, higher no-show rates, and its central diagnostic and therapeutic role.

Colonoscopy (Gold Standard)

- Track referral → scheduling → completion → results documentation
- Automated reminders for appointments and pre-procedure preparation
- Rapid rescheduling for missed visits and navigation support to ensure completion

Stool-Based Tests (FIT, FOBT, FIT-DNA)

- Track order → kit delivery → return → result capture
- Automated reminders for unreturned kits and incomplete tests
- Escalation workflows for non-response and follow-up colonoscopy if positive

Flexible Sigmoidoscopy/CT Colonography

- Track referral → scheduling → completion → results documentation
- Appointment reminders and pre-procedure instructions
- Ensure follow-up colonoscopy for abnormal findings

Patient Navigation Programs

Patient navigation programs play a key role in ensuring that colorectal cancer screening leads to **timely completion and appropriate follow-up**, particularly for patients at risk of falling out of the care pathway. Their impact is greatest after an **abnormal non-colonoscopy test**, where follow-up colonoscopy is required to complete screening and enable definitive diagnosis and potential therapeutic intervention.

Navigation teams, including referral coordinators, help **bridge operational and patient-level gaps** by facilitating scheduling, coordinating with endoscopy or imaging centers, and addressing barriers such as transportation, access, health literacy, or procedural concerns. They also help match patients to the most appropriate pathway based on readiness and clinical need.

Examples include:

- Coordinating **colonoscopy scheduling and preparation support** for patients ready to proceed
- Identifying alternative access strategies (e.g., **mailed stool-based testing**) for patients unable to undergo immediate procedures, with clear plans for follow-up
- Prioritizing patients with **positive results or higher risk** for expedited diagnostic colonoscopy

Effective navigation ensures that screening efforts translate into completed care, reducing delays and improving both clinical outcomes and program performance.



AAVBC PERSPECTIVE

AAVBC encourages plans to design COL programs that **prioritize a closed loop care system** that pairs the right screening modality with the right patient at the right time. Colonoscopies remain the gold standard for early colorectal cancer detection and removal of precancerous lesions.

Achieving this standard enables earlier detection of colorectal cancer when interventions are most effective, improving survival outcomes while simultaneously reducing downstream healthcare utilization associated with late stage disease. Within this framework, non-colonoscopy screening modalities play an important role as **accessible entry points to screening**, particularly for patients who may be hesitant or face barriers to invasive procedures, while also serving as critical pathways to identify individuals who require timely follow-up colonoscopy for definitive diagnosis and/or preventive therapeutic intervention (polypectomy).

4 WORKFLOW OPTIMIZATION AND CODING REMINDERS

Higher Risk Patient Populations

For HEDIS COL reporting, the denominator includes all adults aged 45 to 75 years without exclusions, regardless of individual risk factors. However, certain patients warrant prioritization for **colonoscopy** due to higher clinical risk. ACG guidelines note that a **family history of colorectal cancer confers approximately a 2-fold increased risk**, with greater risk when a first-degree relative is diagnosed before age 60 or when multiple relatives are affected; in these cases, earlier and more frequent colonoscopy is recommended.¹²

Patients with a **personal history of advanced adenomas** are also at elevated risk and require colonoscopy-based surveillance rather than average-risk screening pathways.¹⁵ Additionally, symptoms such as **rectal bleeding, change in bowel habits, or unexplained anemia** should prompt diagnostic colonoscopy, as these are common presenting features in colorectal cancer and are associated with delays in diagnosis if not promptly evaluated.¹⁶

While these factors do not alter HEDIS denominator criteria, they are critical for **clinical prioritization and earlier detection**, supporting improved outcomes beyond COL performance.

Pre-Visit Planning

Proactive pre-visit planning is essential to **identify and engage patients** in the COL denominator before care gaps persist. Care teams should use **registries and EHR tools** to flag eligible patients

aged 45–75 who are due or overdue for screening, enabling targeted outreach in advance of visits. This includes prioritizing patients who have not had a recent annual or preventive visit and scheduling office visits or outreach encounters to address screening needs.

Pre-visit workflows should also ensure that screening status, prior results, and outside records are **reconciled**, allowing clinicians to make informed, real-time recommendations. Embedding reminders into scheduling and intake processes helps ensure that colorectal cancer screening is consistently addressed during visits, improving both completion rates and accurate documentation for HEDIS reporting.

Point-of-Care Decision Support

At the point of care, eligible patients should be **clearly flagged within the EHR**, with care gap alerts visible to the clinical team. The EHR should support **prepopulated order sets** to streamline ordering and reduce workflow friction.

Providers should use the visit to **review screening options with the patient**, emphasizing **colonoscopy as the preferred, gold standard modality** given its diagnostic and therapeutic benefits. For patients who are unwilling or unable to proceed with colonoscopy, clinicians should offer **appropriate alternative screening options** (e.g., FIT or other approved tests), with clear guidance on next steps and the need for follow-up colonoscopy if results are abnormal.

Embedding this structured approach into point-of-care workflows helps ensure consistent screening discussions, efficient ordering, and accurate documentation aligned with HEDIS requirements.

Coding Pitfall to Avoid for CRC Screening Documentation

SCREENING MODALITY	CODES (CPT/HCPCS/ICD-10)	COMMON PITFALLS/CODING ERRORS
Colonoscopy	CPT: 44388–44408, 45378–45398 HCPCS: G0105, G0121	• Missing historical colonoscopy documentation • Procedure done but not coded or captured in EHR • External records not reconciled
Flexible Sigmoidoscopy	CPT: 45330–45350 HCPCS: G0104	• Incorrect interval assumptions • Not capturing older procedures within lookback window
CT Colonography	CPT: 74261, 74262, 74263	• Imaging results not linked to screening indication • Missing documentation of test completion
FOBT (gFOBT/FIT)	CPT: 82270 (gFOBT), 82274 (FIT) HCPCS: G0328	• In-office FOBT (e.g., DRE stool test) does NOT count • Test ordered but not returned • Lab completion not documented
Stool DNA (FIT-DNA)	CPT: 81528	• Misclassification as FIT • Missing lab/vendor documentation

SCREENING MODALITY	CODES (CPT/HCPCS/ICD-10)	COMMON PITFALLS/CODING ERRORS
Screening Encounter/Intent	ICD-10-CM: Z12.11	• Using Z12.11 alone does NOT close gap • No procedure/test documented

Annual Clinical Review and Confirmation

COL compliance is modality-dependent, not annual recertification; FIT/gFOBT require **annual completion**; colonoscopy/FIT-DNA/sigmoidoscopy/CT colonography use multi-year lookback windows

- **Stool-based tests (FIT, gFOBT):** Must be **completed every measurement year** to maintain numerator compliance
- **Multi-year modalities (colonoscopy, FIT-DNA, sigmoidoscopy, CT colonography):** Verify that the **most recent test date falls within the appropriate lookback window as of December 31** of the measurement year
- **Annual Wellness Visits (AWVs):** Use each visit to **review and document screening status**, even for compliant patients, to support **gap identification** and future recall planning
- **EHR optimization:** Track **modality-specific due dates and expiration timelines** to trigger proactive outreach before patients fall out of compliance

Good Documentation is Comprehensive Screening Capture

Accurate, complete documentation is essential to ensure that colorectal cancer screening is fully captured for both clinical care and HEDIS reporting. Within a closed-loop care framework, screening must be **ordered, completed, results acknowledged, and appropriate follow-up actions documented**, ensuring that no step in the care pathway is missed or unrecorded.

INSUFFICIENT DOCUMENTATION	COMPREHENSIVE DOCUMENTATION
Colonoscopy noted in history but no procedure date	Full procedure report: date, prep quality, cecal intubation, findings, next screening interval
FIT ordered but no result documented	FIT result with specimen collection date, result (positive/negative), and follow-up plan
Screening coded as diagnostic procedure	Correct screening CPT (G0121/G0105) with appropriate diagnosis code distinguishing screening from diagnostic
Positive FIT documented but no colonoscopy follow-up	Positive FIT result with documented referral, colonoscopy scheduling, and completion tracking within 90 days
Screening reported (including hybrid/supplemental data) but result not documented	Screening documented with test type, date of service, result, and data source (claims, supplemental, or chart review)

EHR Tips

Accurate and complete EHR documentation is foundational to strong COL performance, as HEDIS and Star Ratings rely on structured data capture rather than clinical intent alone. Optimizing EHR workflows to consistently record screening modality, date, results, and external documentation ensures that completed screenings are appropriately counted toward measure compliance. Standardized templates, discrete data fields, and reconciliation of outside records (e.g., prior colonoscopies) can help close documentation gaps, while embedded reminders and care gap alerts support proactive screening management. Thoughtful EHR configuration enables care teams to reliably identify eligible patients, track screening status, and sustain performance at HEDIS and Star Rating standards.

SMARTPHRASE

.CRC_SCREEN — Screening status, last date/modality, next due date, preferred modality, follow-up plan

SMARTPHRASE

.CRC_MEAT — Pre-structured MEAT template: Monitoring (status assessed), Evaluating (risk/modality), Assessing (results communicated), Treating (follow-up plan)

WORKFLOW

.CRC_POSITIVEFIT — Positive FIT workflow: result communication, colonoscopy referral, scheduling tracking, navigation assignment

BPA TRIGGER

Fire when screening-eligible member presents for any visit type and COL gap exists in registry

ORDER SET

"CRC Screening Panel" — colonoscopy referral, FIT distribution, patient education, follow-up scheduling

5 COMPREHENSIVE DOCUMENTATION AND SUPPLEMENTAL DATA

Accurate, complete, and structured documentation is essential to ensure colorectal cancer **screening and eligible exclusions are fully captured** for HEDIS reporting. Both screening completion and exclusion criteria must be supported by verifiable coding, claims, or medical record documentation, with preference for discrete EHR fields over free text.

Documentation Requirements for Screening Modality

Colonoscopy (10-year)

- **CPT:** 45378–45398; HCPCS: G0105, G0121

FIT/FOBT (annual)

- **CPT:** 82274 (FIT), 82270 (gFOBT); HCPCS: G0328

Stool DNA (3-year)

- **CPT:** 81528

Flexible Sigmoidoscopy (5-year)

- **CPT:** 45330–45350; HCPCS: G0104

CT Colonography (5-year)

- **CPT:** 74261–74263

Documentation Requirements for Exclusion Criteria (Frailty/Advanced Illness Focus)

Frailty (CMS member ≥ 66 years; ≥ 2 indicators on different dates). Common ICD-10-CM codes include:

- R54 (age-related debility)
- R26.2, R26.81 (mobility impairment)
- M62.81 (muscle weakness)
- Z91.81 (history of falls)
- R53.1 (weakness)
- W19.xxx (falls)

Supporting CPT/HCPCS (functional impairment evidence):

- Durable medical equipment: E0143–E0144 (walker), E0163 (commode)
- Home health services: G0151–G0156, T1019

Advanced illness (one pathway required):

- ≥ 2 encounters with conditions such as dementia (F01.x–F03.x), heart failure (I50.x), COPD (J44.x), CKD stage 4–6 (N18.4–N18.6)
- OR dementia medication (e.g., donepezil, memantine)

NOTE: Laboratory claims do not count toward exclusion criteria

For other exclusion coding related to colorectal cancer history, total colectomy, and hospice/palliative care:

→ Refer to **Measure Snapshot** section

Chart Review Best Practices

Accurate chart review is critical for hybrid HEDIS reporting and requires complete, verifiable, and audit-ready documentation. Records must clearly support that screening was performed, completed, and appropriately documented, not just ordered or discussed.

Core Auditor Checklist (All Modalities):

- **Date of service** (not order date)
- Screening modality/test type
- **Result** (e.g., negative, positive, findings)

- **Data source** (lab report, procedure note, external record)
- **Provider attribution/signature** (as applicable)

Colonoscopy-Specific Requirements:

- Full **procedure report** (not just history notation)
- **Date of procedure** within lookback window
- Cecal intubation confirmation
- Bowel prep quality
- **Findings and interventions** (e.g., polypectomy)
- Recommended follow-up interval

Stool-Based Testing (FIT, FOBT, FIT-DNA):

- **Lab report required** with **specimen collection date** (not order date)
- Documented **result** and **follow-up plan if positive**
- Ensure test was **completed and returned**, not just distributed

Other Modalities (Sigmoidoscopy, CT Colonography):

- Procedure or imaging report **with date and findings**
- Clear indication that test was performed for **screening**

Common Documentation Pitfalls to Avoid:

- Screening noted as “up to date” without supporting details
- Missing **test date or result**
- External screenings not **validated or reconciled** into the EHR
- Positive results without documented **follow-up colonoscopy**
- Misclassification of **diagnostic vs screening procedures**

Documentation Recovery Opportunity

Supplemental data submission is the **single highest-yield documentation strategy** for plans with fragmented provider networks. Screenings may sometimes not have administrative claims submitted (e.g., Veterans Affairs or mobile free screening events). Systematic supplemental data capture can recover **5-15% of otherwise uncaptured screenings**.

6 PERFORMANCE MANAGEMENT AND DASHBOARDS

Monitoring Cadence

FREQUENCY	METRIC	OWNER
Daily	FIT kits mailed, FIT kits returned, positive FIT results requiring follow-up	Operations team
Weekly	Screening gap closure rate, navigation caseload, colonoscopy scheduling pipeline	Program manager
Monthly	Overall COL compliance rate by provider/clinic, disparity metrics by race/ethnicity/dual status	Quality leadership
Quarterly	Trend analysis, Star Rating projection, intervention ROI assessment	Executive/Stars team

Dashboard KPIs

Core KPIs:

- 1. COL Numerator Compliance Rate (overall and stratified by subpopulation)**
 - Primary measure of HEDIS performance and Star Rating impact
- 2. Colonoscopy Completion Rate (Preferred Modality)**
 - Tracks proportion of eligible members completing colonoscopy
 - Reflects alignment with **gold standard, one-step screening strategy**
- 3. Positive Non-Colonoscopy Test → Colonoscopy Completion Rate**
 - Target: ≥80% within 3 months; ≥95% within 6 months (AGA guidance)
 - Critical closed-loop metric ensuring non-invasive tests translate to definitive care
- 4. Screening Modality Mix (Colonoscopy vs Non-Invasive Tests)**
 - Monitors reliance on stool-based testing vs colonoscopy
 - Supports shift toward **earlier detection and prevention-focused strategies**
- 5. Provider-Level Screening Performance (Peer Comparison)**
 - Identifies high- and low-performing providers
 - Enables targeted intervention and best practice dissemination
- 6. Never-Screened Population and Outreach Penetration**
 - Tracks engagement of highest-risk, previously unscreened members

- High-impact group for improving both outcomes and Stars performance

7. Health Equity Gap (Dual/LIS vs Non-Dual)

- Measures disparities in screening rates
- Supports targeted, equity-focused interventions

High-performing programs do not just increase screening rates, they ensure that patients complete **colonoscopy when indicated**, enabling earlier-stage detection, prevention through polypectomy, and avoidance of high-cost late-stage disease

Reasons to Select Colonoscopy Over Other Screening Modalities

A key limitation of non-invasive screening pathways is incomplete follow-up after abnormal results, which directly impacts both outcomes and performance. Real-world data show that **16-38% of patients with a positive FIT do not complete follow-up colonoscopy**, and delays beyond recommended intervals are associated with increased colorectal cancer incidence, more advanced stage at diagnosis, and higher mortality risk.¹⁷ Additionally, follow-up rates in practice are often suboptimal, with only **~60% completing colonoscopy within 6 months** in some health systems, highlighting a persistent care gap.¹⁸ Ensuring timely colonoscopy after abnormal screening is therefore critical to achieving effective cancer detection and HEDIS COL performance.

7 FINANCIAL MODELING AND ROI

Downstream Clinical Cost Avoidance

Early detection of colorectal cancer has a well-documented impact on both clinical outcomes and total cost of care in the United States. Claims-based analyses show that initial treatment costs for non-metastatic (**early-stage**) colorectal cancer are **approximately \$182,000 per patient**, compared with **~\$353,000** for metastatic (**late-stage**) disease, reflecting substantially higher utilization of chemotherapy, hospitalizations, and emergency care in advanced disease.¹⁹ Over shorter time horizons, similar trends are observed, with 6-month treatment costs of ~\$29,000–\$32,000 for localized disease versus ~\$47,000–\$52,000 for metastatic disease.²⁰ Scaled to a population level, this translates to ~\$182M vs ~\$353M per 1,000 patients for early vs late stage disease in the first year of care, underscoring the significant economic burden associated with delayed diagnosis. These differences reinforce the value-based care imperative to prioritize screening strategies that shift diagnosis toward earlier stages, where treatment is less intensive, more effective, and avoids substantial downstream healthcare utilization.

Financial Modeling for Patients Undergoing Colonoscopy-Based Screening (Per 1000 Patients)

COMPONENT	PERFORMED AT ASC	PERFORMED AT HOSPITAL OUTPATIENT FACILITY	NOTES
Screening Colonoscopy (Professional + Facility)²¹	~\$830,000	~1,400,000	~\$800-\$1,200 per case (ASC) vs \$1,500-\$2,500+ (HOPD); CMS pays higher facility fees in hospital settings
Anesthesia Services	\$150,000-\$300,000	\$200,000-\$400,000	~\$150-\$300 per case; often bundled but varies by contract
Pathology (Biopsy/ Polypectomy)^{22,23}	\$859,000-\$879,000	\$1,425,000-\$1,445,000	Depends on polyp detection rate (~25-40%)
Pre-procedure visits/ clearance	\$50,000-\$100,000	\$75,000-\$150,000	Includes consults, labs, risk stratification
Patient navigation/ scheduling	\$25,000-\$50,000	\$25,000-\$50,000	Required to drive completion and reduce no-shows
Missed appointment/ rescheduling costs	\$25,000-\$75,000	\$50,000-\$100,000	Higher no-show cost burden in hospital settings
Complication-related costs (low incidence)	\$10,000-\$30,000	\$15,000-\$50,000	Rare but higher cost exposure in HOPD
Total Estimated Cost/ 1,000 Screenings	~\$1.2M-\$1.9M	~\$2.0M-\$3.5M	Reflects full procedural pathway including polypectomy

Figures are illustrative estimates for modeling purposes only and may vary by plan, market, and contract

Financial Modeling for Patients Opting for FIT Screening (Per 1000 Patients)

COMPONENT	ESTIMATED COST/ 1,000		NOTES
FIT kits (materials + postage)	\$5,000-\$8,000	~\$5-8/kit including mailing	

COMPONENT	ESTIMATED COST/ 1,000	NOTES
Patient navigation (0.5 FTE/ 1,000 gaps)	\$25,000–\$35,000	Staff-intensive; highest-yield intervention
Text/IVR reminder platform	\$1,000–\$3,000	+2.8 pp at \$0.66/patient incremental cost
EHR optimization (BPAs, order sets)	\$10,000–\$25,000 (one- time)	Infrastructure; reusable across measures
Printing/mailing (letters, reminders)	\$2,000–\$4,000	Ongoing annual cost
Total Annual Program Cost	~\$33,000–\$50,000	Excludes one-time EHR investment

Important Note: Patients with positive FIT tests must complete follow-up colonoscopies.

Figures are illustrative estimates for modeling purposes only and may vary by plan, market, and contract

ROI Framework: Closing COL Gaps

For a 50,000-member Medicare Advantage plan, approximately **25,000 members are COL-eligible** (age 45-75 without exclusion criteria). Improving screening performance from a **70% baseline to an 80% target** requires closing **~2,500 care gaps**, representing a high-leverage opportunity for Star Rating improvement. Evidence-based outreach programs remain relatively low cost; for example, the PROMPT trial demonstrated **~\$10.84 per patient for standard mailed outreach, with an incremental ~\$0.66 per patient for enhanced text and automated call support**. Scaled to the target population, this equates to an estimated **\$125K–\$250K annual investment**, depending on program intensity and navigation support.

In contrast, achieving ≥ 4 Stars unlocks a **~5% Quality Bonus Payment (QBP)** applied to benchmark revenue, translating to **tens of millions of dollars annually** for a plan of this size. Because COL is a high-volume measure with clustered cut points, relatively modest improvements in screening rates can shift overall Star performance. From a value-based perspective, these investments also support **earlier cancer detection and prevention**, reducing downstream utilization and total cost of care beyond the immediate financial return.



AAVBC PERSPECTIVE

Financial returns from CRC screening programs are a consequence of **improving care quality and patient outcomes**, not the objective. The gold standard screening method, colonoscopy, provides additional value-based care returns based on its early detection and removal of precancerous lesions. The overall goal of the HEDIS COL screening measure is ensuring every eligible individual receives timely, evidence-based screening that can prevent cancer or detect it early when treatment is most effective. AAVBC frames investment modeling as a tool for **resource allocation**, not revenue optimization.

8 REGULATORY AND SPECIFICATION UPDATES

USPSTF Recommendation Status

The 2021 USPSTF colorectal cancer screening recommendations **remain current**, with no finalized update as of today. Screening is recommended for adults aged **50-75 years (Grade A)**, **45-49 years (Grade B)**, and selectively for **76-85 years (Grade C)** based on individual factors.

USPSTF typically updates recommendations on an approximately 5-year cycle, and while stakeholder pressure and emerging technologies (e.g., blood-based tests) may accelerate review, the next update is anticipated in the **2026-2027 timeframe**.

2025-2026 HEDIS Specification Changes

Recent HEDIS specifications reflect alignment with national guidelines and evolving screening practices:

- **Age range standardized to 45-75**, consistent with USPSTF and multi-society guidance
- **DA-approved blood-based screening tests are not currently HEDIS-qualifying**, as evidence and guideline endorsement remain limited
- **Telehealth visits for CRC counseling are reimbursable**, but **do not satisfy numerator requirements** without completion of an approved screening test

Key implication: HEDIS continues to require **completed, evidence-based screening modalities**, not intent or counseling alone.

Other Guideline Bodies (ACS, MSTF, ACG, NCCN)

Major clinical organizations continue to shape screening practice patterns and future policy direction:

- **ACS, MSTF, ACG, and NCCN all support initiation of screening at age 45**, reinforcing earlier detection strategies
- These organizations influence **screening modality selection**, balancing stool-based testing with direct visualization strategies based on patient risk and preference
- **NCCN (v1.2026) and other updated guidelines** continue to refine risk stratification, surveillance intervals, and prevention strategies
- Guideline alignment across societies increases **provider adoption and documentation consistency**, and often **precedes future HEDIS specification updates**

Blood-Based CRC Screening Tests — Regulatory Landscape

DIMENSION	CURRENT STATUS	OPERATIONAL IMPLICATION
FDA Approval	Shield (Guardant Health) FDA-approved	Available clinically; NOT HEDIS-QUALIFYING
CMS Coverage	Proposed: q3yr, ages 45–85, ≥74% sensitivity, ≥90% specificity	Coverage ≠ HEDIS inclusion
HEDIS Inclusion	NOT in current COL specifications	Monitor NCQA annual updates
Clinical Utility	Convenience for hard-to-reach populations	May increase engagement; does not close COL gap

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