CareSource | NETWORK Notification

Notice Date: **January 18, 2023**
To: **All Marketplace Providers**
From: **CareSource**
Subject: **Cancer Screening Compliance Coding**

Summary
Throughout the year, CareSource may reach out to members and providers with reminders about certain types of screenings and other health services to attempt to close identified gaps in care. It's easy to let CareSource know when your patient isn't due for routine cancer screenings by including ICD-10 and CPT® Category II codes on your claims.

Impact
Accurate reporting allows you to identify patients due for breast, cervical and/or colorectal cancer screenings. Closing these gaps results in improved quality scores for your practice. Exclusionary codes remove patients who should not be included in your gap-in-care (or Clinical Practice Registry [CPR]) report.

Requirements
To meet compliance requirements for the quality measure, the patient record for those who have completed their screenings should reflect the following information:

Breast and **cervical cancer** screenings: Your patient's record must include a copy of the results in order to submit the specified CPT II or ICD-10 code.

Colorectal cancer screenings:

- Stool DNA (sDNA) with FIT test during measurement year or two years prior.
- A copy of the report is required for the fecal immunochemical test (FIT) or fecal occult blood (guaiac) test (gFOBT) completed during the measurement year.
- A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed.
- Flexible sigmoidoscopy during the measurement year or four years prior.
- Colonoscopy during the measurement year or nine years prior. Previous colonoscopies do not require a copy of the results in the patient's records, but CareSource recommends obtaining a copy as best practice. If you cannot obtain the colonoscopy report, documentation in the assessment portion of the visit note must include where and when the exam happened and results of the exam.
- CT colonography during the measurement year or four years prior.
- A result is not required if the documentation is clearly part of the member's "medical history".

The following coding details are for your reference and not a guarantee of payment. Additional quality guides are located on the "Quick Reference Materials" page at **CareSource.com.** If you have questions, please call Marketplace Provider Services **1-833-230-2101** or contact your Health Partner Representative.

Qualifying Condition and/or Code	CPT II / ICD-10 Code	Code Definition
Breast Cancer Screening		
ICD-10: History of Bilateral Mastectomy	Z90.13	Acquired absence of bilateral breasts and nipples
	Z90.12	Acquired absence of left breast and nipple
	Z90.11	Acquired absence of right breast and nipple
Cervical Cancer Screening		
ICD-10: History of Total Hysterectomy	Q51.5	Agenesis and aplasia of cervix
	Z90.710	Acquired absence of both cervix and uterus
	Z90.712	Acquired absence of cervix with remaining uterus
Colorectal Cancer Screening		
ICD-10 History of colorectal cancer	Z85.038	Personal history of other malignant neoplasm of large intestine
	Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus

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