Colonoscopy Copays

Everything you need to know about colonoscopy copays, including how one health plan made the switch to waiving copays

Tuesday, April 12th, 2016
1:00pm EST
Purpose of Today’s Webinar

• Provide an update on federal and state efforts to remove cost sharing for CRC screening
• Explain what’s covered with respect to colorectal cancer screening, what’s not covered and how to code for it
• Describe a case study in which Gateway Health of Pennsylvania plan removed copays for colonoscopies following positive FIT tests
• Q&A
Presenters:

Holly Wolf, PhD, MSPH (Moderator)
Co-Chair, NCCRT Policy Action Task Group
Director, Colorado Colorectal Screening Program

Caroline Powers, Director, Federal Relations, American Cancer Society Cancer Action Network, Inc.

Joel Brill, MD, Chair, Payor Policy Workgroup, American Gastroenterological Association

Marnie Schilken, MPH, Director, Population Health Strategies, Quality Improvement, Gateway Health SM,
Remaining Barriers to Colorectal Cancer Screening

Caroline Powers, Director Federal Affairs
Affordable Care Act
Screenings are covered now, *right*?

• Eliminated cost-sharing for colorectal cancer screenings grade “A” or “B” by the USPSTF

• The Administration has clarified some of the ancillary services related to CRC screenings that should be covered for private insurance and Medicare.

• However, outstanding issues remain particularly in Medicare but also in private insurance creating confusion patients and providers.
Efforts to Address Barriers

• **Legislative**
  • HR 1220/S 624, the Removing Barriers to Colorectal Cancer Screening Act of 2015

• **Administrative**
  • Clarification is needed for both Medicare and Private Insurance that follow-up colonoscopy should be covered without cost-sharing
## CRC Screening in Medicare

<table>
<thead>
<tr>
<th>Medicare plans</th>
<th>First line colonoscopy screening – no polyp discovered</th>
<th>First line colonoscopy screening -- polyp is discovered</th>
<th>Colonoscopy following a positive stool test with or without polyp discovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered; free of cost sharing</td>
<td>Covered; no deductible, but coinsurance applies</td>
<td>Covered; but both deductible and coinsurance apply</td>
<td></td>
</tr>
</tbody>
</table>
Barriers to Screening
Legislative Priority

- HR 1220/ S 624 the Removing Barriers to Colorectal Cancer Screening Act of 2015
  - Simply fixes the glitch in Medicare so that when a polyp is removed during a screening colonoscopy, Seniors will not be hit with a surprise bill
  - Bipartisan Legislation in both the House (Dent/Payne) and the Senate (Brown/Wicker)
  - Overwhelming bipartisan support in both Chambers
HR 1220/S 624
Removing Barriers to Colorectal Cancer Screening Act

Imagine going into a colonoscopy you *think* is fully covered by insurance, only to come out of it and find out afterward that not only did the doctor find a polyp, but you’re being charged for its removal.

There’s an easy fix to this problem that affects many Americans who are 65 and older. Take a minute, click on the link and ask your lawmaker to save lives from colon cancer. [http://goo.gl/SZzqne](http://goo.gl/SZzqne)
The ‘Removing Barriers to Colorectal Screening Act’ (S 624/HR 1220) would eliminate cost sharing for seniors on Medicare, even if a polyp is removed.

SAVE LIVES. Pass S 624 and HR 1220.
Follow-up colonoscopy

- USPSTF notes “follow-up of positive screening test results requires colonoscopy regardless of the screening test used.”
- 2008 Joint Guidelines issued by the American Cancer Society, the United States Multisociety Task Force on Colorectal Cancer (ACS/MSTF) and the American College of Radiology
Medicare: Follow-up colonoscopy

- Currently, Seniors on Medicare are responsible for both the deductible and coinsurance when a colonoscopy that is ordered as a follow up to a positive colorectal cancer screening test, such as high sensitivity stool testing, is performed.
CRC Screening in Private Insurance

The Administration has clarified several issues related to screening colonoscopy

- 2013: Polyp removal
- 2015: Pre-colonoscopy exam, consultation, anesthesia, and pathology
CRC Screening in Private Insurance  
Follow-up Colonoscopy

• Screening for colorectal cancer by high sensitivity stool test is inexpensive and effective, but it must be treated as a two-step screening process if the stool test is positive.

• Although some health plans have already adopted a policy that covers follow-up colonoscopy, it is not uniform. Clarification for qualified health plans is still needed from the Administration.
State Activities

• Access to Care
  • Medicaid Expansion – 20 non-expansion states
  • CDC Colorectal Cancer Control Program – limited program reach → direct screening services funded for 6 programs in current grant cycle
State Decisions on Increasing Access to Health Care Through Medicaid Up to 138% FPL

- State has broadened Medicaid eligibility, covering individuals under 138% FPL
- Legislature still in session or executive pursuing 1115 waiver / alternative expansion proposal – federal approval pending, final decision is unknown
- Governor/legislature opposed to improving access to health care coverage through Medicaid, includes estimated number of individuals under 100% Federal Poverty Level (FPL) in coverage gap

Source: ACS CAN and Kaiser Family Foundation: A Closer Look at the Impact of State Decisions Not to Expand Medicaid on Coverage for Uninsured Adults
- Updated November 2015
Colonoscopy: Coding and Cost Sharing

Joel V. Brill MD FACP AGAF
Definition of Colorectal Cancer (CRC) Screening Tests

- CMS has revised the definition of “colorectal cancer screening tests” to include anesthesia that is separately furnished in conjunction with screening colonoscopies.
- The Affordable Care Act requires 100 percent Medicare payment of the fee schedule amount for those “preventive services” that are appropriate for the individual and are recommended with a grade of A or B by the USPSTF.
Definition of CRC Screening Tests

- The Affordable Care Act waives any Part B coinsurance that would otherwise apply for certain recommended preventive services, including screening colonoscopies.
- Effective January 1, 2015: expenses incurred for a screening colonoscopy, and the anesthesia services furnished in conjunction with such tests, will not be subject to the Part B deductible and will not count toward meeting that deductible.
When a CRC screening becomes a procedure

- The Affordable Care Act, waives the Part B deductible for “colorectal screening tests regardless of the code billed for the establishment of a diagnosis as a result of the test, or the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test.”


- The statutory waiver of deductible will apply to the anesthesia services furnished in conjunction with a colorectal cancer screening test even when a polyp or other tissue is removed during a colonoscopy.
Patient responsibility when a CRC screening becomes a procedure

- Section 1834(d)(3)(D) of the Act states that, “[i]f during the course of such a screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.”


- As a result, when an anticipated screening colonoscopy ends up involving a biopsy or polyp removal, Medicare cannot pay for this procedure as a screening colonoscopy.
  - Medicare pays 80 percent of the diagnostic colonoscopy procedure and the beneficiary is responsible for paying Part B coinsurance.
  - Similarly, the beneficiary is responsible for paying Part B coinsurance for any covered anesthesia.
Effective January 1, 2015, Anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a colorectal cancer screening test should include the 33 modifier on the claim line with the anesthesia service.

In situations that begin as a colorectal cancer screening test, but for which another service such as colonoscopy with polyp removal is actually furnished, the anesthesia professional should report a PT modifier on the claim line rather than the 33 modifier.


This final rule with comment period establishes national policy and takes precedence over any local coverage policy that limits Medicare coverage for anesthesia services furnished during a screening colonoscopy by an anesthesia professional.

DoL and Screening Colonoscopy


The following are now covered without patient financial responsibility when provided as part of screening colonoscopy:
- Pre-procedure E/M
- Pathology

Because the Departments' prior guidance may reasonably have been interpreted in good faith as not requiring coverage without cost sharing when performed in connection with a colonoscopy screening procedure, the Departments will apply this clarifying guidance for plan years (or, in the individual market, policy years) beginning on or after the date that is 60 days after publication of these FAQs (e.g. December 23, 2015)

- Silent regarding coverage of prep prior to colonoscopy
- Guidance does not apply to Medicare
Q7: If a colonoscopy is scheduled and performed as a screening procedure pursuant to the USPSTF recommendation, is it permissible for a plan or issuer to impose cost sharing for the required specialist consultation prior to the screening procedure?

A: No. The plan or issuer may not impose cost sharing with respect to a required consultation prior to the screening procedure if the attending provider determines that the pre-procedure consultation would be medically appropriate for the individual, because the pre-procedure consultation is an integral part of the colonoscopy. As with any invasive procedure, the consultation before the colonoscopy can be essential in order for the consumer to obtain the full benefit of the colonoscopy safely. The medical provider examines the patient to determine if the patient is healthy enough for the procedure and explains the process to the patient, including the required preparation for the procedure, all of which are necessary to protect the health of the patient.
Q8: After a colonoscopy is scheduled and performed as a screening procedure pursuant to the USPSTF recommendation, is the plan or issuer required to cover any pathology exam on a polyp biopsy without cost sharing?

A: Yes, such services performed in connection with a preventive colonoscopy must be covered without cost sharing. The Departments view such services as an integral part of a colonoscopy, similar to polyp removal during a colonoscopy. The pathology exam is essential for the provider and the patient to obtain the full benefit of the preventive screening since the pathology exam determines whether the polyp is malignant. Since the primary focus of the colonoscopy is to screen for malignancies, the pathology exam is critical for achieving the primary purpose of the colonoscopy screening.
Reporting pathology with screening colonoscopy

- In situations that begin as a colorectal cancer screening test, but for which another service such as colonoscopy with polyp removal is actually furnished, the pathology professional should report:
  - Medicare: PT modifier on the claim line
  - Commercial: 33 modifier on the claim line.
Beneficiary coinsurance when CRC screening procedure performed in facility

- **Effective January 1, 2007:**
  - Section 1834(d)(2) of the Social Security Act imposes a beneficiary coinsurance of 25 percent for colorectal cancer screening flexible sigmoidoscopies that are performed in hospital outpatient departments (HOPD).
  - Section 1834(d)(3) of the Social Security Act imposes a beneficiary coinsurance of 25 percent for colorectal cancer screening colonoscopies that are performed in Ambulatory Surgical Centers (ASCs) and in HOPD.

- CR 5387, transmittal 1160
### Commercial

<table>
<thead>
<tr>
<th></th>
<th>Screening</th>
<th>Screening, Polyp Found</th>
<th>Diagnostic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>The plan or issuer may not impose cost-sharing with respect to anesthesia services performed in connection with the screening colonoscopy if attending provider determines that anesthesia would be medically appropriate for the individual. Must be in-network.</td>
<td>Covered if attending provider determines it to be medically appropriate. Must be in-network.</td>
<td>ACA is silent on this issue. Individual insurance policies may vary.</td>
</tr>
<tr>
<td>Co-insurance applies (anesthesia, facility)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Deductible applies (anesthesia, facility)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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</thead>
<tbody>
<tr>
<td><strong>Pre-Procedure E/M visit</strong></td>
<td>The plan or issuer may not impose cost-sharing with respect to E/M services performed in connection with the screening colonoscopy if attending provider determines that visit would be medically appropriate for the individual. Must be in-network.</td>
<td>The plan or issuer may not impose cost-sharing with respect to E/M services performed in conjunction with the screening colonoscopy if attending provider determines that visit would be medically appropriate for the individual. Must be in-network.</td>
<td>ACA is silent on this issue. Individual insurance policies may vary; visit may be subject to cost-sharing and/or co-pays according to plan policy</td>
</tr>
<tr>
<td><strong>Pathology</strong></td>
<td>N/A</td>
<td>The plan or issuer may not impose cost-sharing with respect to pathology performed in conjunction with the screening colonoscopy. Must be in-network</td>
<td>Individual insurance policies may vary; pathology may be subject to cost-sharing and/or co-pays according to plan policy</td>
</tr>
<tr>
<td><strong>Co-insurance and/or deductible applies (E/M, pathology)</strong></td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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</table>
## Medicare

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<th>Diagnostic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>Covered without cost-sharing if no polyp is found and removed</td>
<td>Covered, but coinsurance applies. 20% of the Medicare-approved amount with no Part B deductible.</td>
<td>No</td>
</tr>
<tr>
<td>Pre-procedure E/M visit</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Co-Insurance Applies (anesthesia, facility)</td>
<td>No, unless a polyp is removed.</td>
<td>Coinsurance applies. 20% of the Medicare-approved amount with no Part B deductible. If the test is done in a hospital outpatient department or ambulatory surgical center, 25% of the Medicare-approved amount.</td>
<td>No</td>
</tr>
<tr>
<td>Deductible Applies (anesthesia, facility)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
National Coverage Determination for Colorectal Cancer Screening Tests (210.3)

- Section 4104 of the Balanced Budget Act of 1997 provides for coverage of screening colorectal cancer procedures under Medicare Part B.

- Medicare currently covers:
  - (1) annual fecal occult blood tests (FOBTs);
  - (2) flexible sigmoidoscopy over 4 years;
  - (3) screening colonoscopy for persons at average risk for colorectal cancer every 10 years, or for persons at high risk for colorectal cancer every 2 years;
  - (4) barium enema every 4 years as an alternative to flexible sigmoidoscopy, or every 2 years as an alternative to colonoscopy for persons at high risk for colorectal cancer; and,
  - (5) other procedures the Secretary finds appropriate based on consultation with appropriate experts and organizations.

ICD-10 codes and NCD 210.3

- K50 – Crohn’s disease
- K51 – ulcerative colitis
- K52.1 – toxic gastroenteritis and colitis
- K52.89 – other specified noninfective gastroenteritis and colitis
- K52.9 – noninfective gastroenteritis and colitis, unspecified
- Z85.038 – personal history of other malignant lesion of large intestine
- Z85.048 – personal history of other malignant lesion of rectum, rectosigmoid junction, and anus
ICD-10 codes and NCD 210.3

- D12.6 – benign neoplasm of colon, unspecified
- Z12.11 – encounter for screening for malignant neoplasm of colon
- Z12.12 – encounter for screening for malignant neoplasm of rectum
- Z15.09 – genetic susceptibility of other malignant neoplasm
- Z80.0 – family history of malignant neoplasm of digestive organs
- Z83.71 – family history of colonic polyps
- Z86.010 – personal history of benign neoplasm of colon
Screening vs. Surveillance

- Screening is a service performed on a patient in the absence of signs or symptoms.
  - https://www.noridianmedicare.com/cgi-bin/coranto/viewnews.cgi?id=EkEpkVyyykcUkHClzB&tmpl=part_a_viewnews&style=part_ab_viewnews

- Once the patient is diagnosed with polyps – even hyperplastic polyps – follow-up endoscopy is surveillance, per the 2012 multi society guidelines.

- But…there is no CPT code for surveillance colonoscopy

- Use ICD-10 codes to identify surveillance
Medicare: screening colonoscopy

- Report a screening colonoscopy for a Medicare patient using G0105 (colorectal cancer screening; colonoscopy on individual at high risk) and G0121 (colorectal cancer screening; colonoscopy on individual not meeting the criteria for high risk).

- Medicare beneficiaries without high risk factors are eligible for screening colonoscopy every ten years.
- Beneficiaries at high risk for developing colorectal cancer are eligible once every 24 months.
- Medicare considers an individual at high risk for developing colorectal cancer as one who has one or more of the following:
  - A close relative (sibling, parent or child) who has had colorectal cancer or an adenomatous polyp.
  - A family history of familial adenomatous polyposis.
  - A family history of hereditary nonpolyposis colorectal cancer.
  - A personal history of adenomatous polyps.
  - A personal history of colorectal cancer.
  - Inflammatory bowel disease, including Crohn’s Disease, and ulcerative colitis.

- To report screening colonoscopy on a patient not considered high risk for colorectal cancer, use HCPCS code G0121 and Z12.11 or Z12.12 as appropriate.

- To report screening on a Medicare beneficiary at high risk for colorectal cancer, use HCPCS G0105 and the appropriate diagnosis code that necessitates the more frequent screening.
Eliminating the Co-Pay Cost Share
One health plan’s story

Marnie Schilken
Director, Population Health Strategies & Performance Management
It was such a simple statement.

Patrick Corneya

- “If a patient goes to sleep without a co-pay, she or he should wake up without a co-pay.”
Nov 2013 - NCCRT Annual Mtg
Dr. Patrick Courneya
“Go to sleep with no co-pay,
wake up with no co-pay”
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Dec 2013 – Ask Questions
Member Services & Claims
We asked two “simple” questions.

• Is cost-sharing being applied to Gateway members who have a colorectal cancer screening colonoscopy that “converts” to a diagnostic?

• Is cost-sharing being applied to Gateway members who complete an iFOBT, test positive and thus require follow-up testing?
“As long as provider bills only with the following colorectal screening codes then benefits are reimbursed at 100%”:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0104</td>
<td>Colorectal Cancer Screen - Flexible Sigmoidoscopy</td>
</tr>
<tr>
<td>G0105</td>
<td>Colorectal Cancer Screen - Colonoscopy</td>
</tr>
<tr>
<td>G0106</td>
<td>Colorectal Cancer Screen - Screening Sigmoidoscopy, Barium Enema</td>
</tr>
<tr>
<td>G0120</td>
<td>Colorectal Cancer Screen; screening colonoscopy, barium enema</td>
</tr>
<tr>
<td>G0121</td>
<td>Colorectal Cancer Screen - Colonoscopy</td>
</tr>
<tr>
<td>G0328</td>
<td>Colorectal Cancer Screen; fecal-occult blood test</td>
</tr>
<tr>
<td>82270</td>
<td>Colorectal Cancer Screen - Fecal</td>
</tr>
</tbody>
</table>
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Have a Conference Cal
Two scenarios
Scenario 1
Member’s physician gives member and iFOBT kit OR Gateway sends iFOBT kit and member completes it and gets a **negative result**, these codes should be used:

- **G0105** *(COL screening; colonoscopy on individual at high risk)*
- or –
- **G0121** *(COL screening; colonoscopy on individual not meeting the criteria for high risk)*

Scenario 2
Member’s physician gives member and iFOBT kit OR Gateway sends iFOBT kit and member completes it and gets a **positive result**, then member should be referred to a colonoscopy for follow-up. For that colonoscopy, these codes should be used:

- **45378** *(Standard category 1, diagnostic colonoscopy)*
- **45380** *(with biopsy)*
- **45384** *(with hot biopsy)*
- **45385** *(with polypectomy)*
- +
- **V76.51** *(Special screening for malignant neoplasms of colon)*
- +
- **578.9**
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Jan-Mar 2014 – Do lots of Internal Study
Three scenarios
Lots of questions!

Have a Conference Call
Two scenarios
January 29, 2014
Co-pays and deductibles for all services associated with screening colonoscopies
Workgroup meeting

Boil this down to three scenarios:

<table>
<thead>
<tr>
<th>1. Assumes the colonoscopy started as a Screening</th>
<th>G0105</th>
<th>G0121</th>
<th>Include in provider education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<thead>
<tr>
<th>2. Assumes the colonoscopy started as a Screening</th>
<th>G0105</th>
<th>+</th>
<th>PT modifier</th>
<th>G0121</th>
<th>+</th>
<th>PT modifier</th>
<th></th>
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<th>3. Assumes the colonoscopy started as Diagnostic</th>
<th>45378</th>
<th>+</th>
<th>V76.51</th>
<th>+</th>
<th>578.91</th>
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Do we need to know how often the “PT” modifier is used with G0105 or G0121, and what we pay for each of those?

Mammogram - How many unique mammograms are coded as diagnostic in one year? What are members getting charged for these co-pays?

Does it matter if the diagnosis is placed in the 2nd line and the GI bleeding is placed in the 1st line?

Diabetic eye exam – How many members – diabetic vs non-diabetic – have had an eye exam in the year? What co-pays have members incurred as a result of these exams?

Is the pathology code of 88305 already being paid at 100% (no co-pays to member)?

Colonoscopy – Can we figure out which were upper endoscopies vs colonoscopies?

Anesthesia - What is being billed for anesthesia? What is being denied? What is being paid? Have we ever gotten a 45375 + “OO” code for anesthesia? How did we pay?

What is the Medicare fee schedule for each code – G01015, G0121, 45378, 45380, 45384, and 45385?

Are we ever receiving the V76.51 code from facilities and how are we paying? Do we want/need to also zero out that co-pay, if it is occurring?

Do we need to know how often the “PT” modifier is used with G0105 or G0121, and what we pay for each of those?
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Mar 2014 – Make a Recommendation
Eliminate Cost-Sharing in specific instances.

Have a Conference Call
Two scenarios

Colorectal Cancer Screening
Breast Cancer Screening
Diabetic Retinal Exam
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May 2014 – Get an email

Oct 2014 – Get an email

June 2015 – Get an email

Gateway Health.
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June 2014 – Have a Conference Call
Two scenarios

Sept 2014 – Get an email

May 2015 – Get an email

May 2015 – Enter the Medicare Bid... again

Aug 2015 – Receive an understated email
Claims to Analytics
August 14, 2015 2:05pm

“All CPT/HCPCS codes on the attached spreadsheets have been updated to reimburse at the preventative rate of 100% effective with dates of service 1.1.16 and forward for all Medicare lines of business.”
Claims to Analytics
August 14, 2015 2:05pm

“All CPT/HCPCS codes on the attached spreadsheets have been updated to reimburse at the preventative rate of 100% effective with dates of service 1.1.16 and forward for all Medicare lines of business.”

Analytics to Claims
August 14, 2015 2:22pm

“So if the payment is at a 100% this means that there will be no deductible and/or copayment for the member. Correct?”
Claims to Analytics
August 14, 2015 2:05pm

“All CPT/HCPCS codes on the attached spreadsheets have been updated to reimburse at the preventative rate of 100% effective with dates of service 1.1.16 and forward for all Medicare lines of business.”

Analytics to Claims
August 14, 2015 2:22pm

“So if the payment is at a 100% this means that there will be no deductible and/or copayment for the member. Correct?”

Claims to Analytics
August 14, 2015 2:46pm

“That is correct.”
The Importance of Waiving Cost-sharing for Follow-up Colonoscopies makes the case for health plans to voluntarily waive cost-sharing for colonoscopies that follow a positive stool test.

- Eliminate financial incentive to choose the more $ first line test.
- Potential to increase screening rate and improve quality measures.
Join us for the following upcoming webcast

Thursday, May 5th at 1:00pm EST
Utilizing the Electronic Health Record to Impact Change: Beyond the Pop-Up Reminder
Save the Date – Registration not yet opened

Note: This webinar will provide an in-depth look at our eClinicalWorks Best Practices Workflow and Documentation Guide to support colorectal cancer screening for eClinicalWorks. This webinar is best suited for those who work directly with EHRs, eClinicalWorks in particular and is not an introductory webinar.

nccrt.org/about/provider-education/ehr-best-practice-workflow-and-guide-eclinicalworks/
Thank You!

• Thank you to our presenters!
• Centers for Disease Control and Prevention

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