Breast Cancer Screening: USPSTF, ACS, and CMS *Table Updated April 19, 2024*			
Criteria	**United States Preventive Services Task Force (USPSTF) guidelines here**	**American Cancer Society (ACS) guidelines here**	**Centers for Medicare and Medicaid Services (CMS) guidelines here**
Update Date	April 2024	December 2023	January 2024
Age	40-74	45-54	50+ or those 40 + with family history
	The USPSTF recommends biennial screening mammography for women ages 40 to 74 years.	The ACS recommends annual screening for women at average risk for breast cancer between ages 45 to 54	Routine screening mammograms for asymptomatic women aged 50 and over are considered medically appropriate. Routine screening mammograms for asymptomatic women aged 40 or over whose mothers or sisters have had the disease are also considered medically appropriate.
Frequency	Biennial screening	Annual screening	Annual screening
Other criteria	Age 75 or older: The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women aged 75 years or older. Dense Breasts: The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of supplemental screening for breast cancer using breast ultrasonography or magnetic resonance imaging (MRI) in women identified to have dense breasts on an otherwise negative screening mammogram.	Age 40 to 44: Women between age 40 and 44 have the option to start screening with a mammogram every year. Age 55 or older: Women aged 55 or older can switch to a mammogram every other year, or they can choose to continue yearly mammograms. Screening should continue if a woman is in good health and is expected to live at least 10 more years. All women should understand what to expect when getting a mammogram for breast cancer screening – what the test can and cannot do.	Payment may not be made for a screening mammography performed on a woman under age 35. Payment may be made for only one screening mammography performed on a woman over age 34, but under age 40. For an asymptomatic woman over age 39, payment may be made for a screening mammography performed after at least 11 months have passed following the month in which the last screening mammography was performed.

Other criteria continued	**USPSTF** See the "Practice Considerations" section for more information on the patient population to whom this recommendation applies and on screening mammography modalities.		

Cervical Cancer Screening: USPSTF, ACS, and CMS *Table Updated April 19, 2024*			
Criteria	**United States Preventive Services Task Force (USPSTF) guidelines here**	**American Cancer Society (ACS) guidelines here**	**Centers for Medicare and Medicaid Services (CMS) guidelines here & here**
Update Date	August 2018; Currently in Progress	April 2021	June 2006 and July 2015
Age	21-65	25-65	30-65
	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).	The American Cancer Society recommends that individuals with a cervix who have not been diagnosed with cervical cancer or cervical pre-cancer should be screened starting at age 25. These women should have follow-up testing and cervical cancer screening as recommended by their health care team. Those aged 25 to 65 should have a primary HPV test* every 5 years. If primary HPV testing is not available, screening may be done with either a co-test that combines an HPV test with a Papanicolaou (Pap) test every 5 years or a Pap test alone every 3 years. (*A primary HPV test is an HPV test that is done by itself for screening. The US Food and Drug Administration has approved certain tests to be primary HPV tests.)	A woman should have a screening Pap smear and pelvic examination every two years if she: Has not had such a test during the preceding two years. Is a woman of childbearing age. The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to add Human Papillomavirus (HPV) testing once every five years as an additional preventive service benefit under the Medicare program for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test. CMS will cover screening for cervical cancer with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations.

Criteria	USPSTF	ACS	CMS
Frequency	High-risk human papillomavirus (hrHPV) testing alone (primary HPV test) every 5 years; OR hrHPV testing combined with Pap Test every 5 years; OR or a Pap test (cervical cytology) alone every 3 years	Primary HPV test* every 5 years; If primary HPV testing is not available, screening done with a co-test that combines an HPV test with a Pap Test every 5 years; or a Pap test alone every 3 years *Primary HPV test (hrHPV) is an HPV test done by itself for screening	Biannual screening for cervical cancer; Primary HPV testing every 5 years
Other criteria	Women under 21: The USPSTF recommends against screening for cervical cancer in women younger than 21 years. See the Clinical Considerations section for the relative benefits and harms of alternative screening strategies for women 21 years or older. Women who have had a hysterectomy: The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.	Those over age 65 who have had regular screening in the past 10 years with normal results and no history of CIN2 or more serious diagnosis within the past 25 years should stop cervical cancer screening. Once stopped, it should not be started again. Those who have had a total hysterectomy (removal of the uterus and cervix) should stop screening (such as Pap tests and HPV tests) unless the hysterectomy was done as a treatment for cervical cancer or serious pre-cancer. People who have had a hysterectomy without removal of the cervix (called a supra-cervical hysterectomy) should continue cervical cancer screening according to the guidelines above. People who have been vaccinated against HPV should still follow these guidelines for their age groups.	If there is evidence (based on her medical history or other findings) that the woman is at high risk of developing cervical cancer, and her physician or authorized practitioner recommends it, she may need the test performed more frequently than every two years.

Other criteria continued	**USPSTF** Women older than 65: The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. See the Clinical Considerations section for discussion of adequate prior screening and risk factors that support screening after age 65 years.	**ACS** Some people believe that they can stop cervical cancer screening once they have stopped having children. This is not true. They should continue to follow American Cancer Society guidelines. Those who have a history of a serious pre-cancer should continue to have testing for at least 25 years after that condition was found, even if the testing goes past age 65.	

Colorectal Cancer Screening: USPSTF, ACS, and CMS *Table Updated April 19, 2024*			
Criteria	**United States Preventive Services Task Force (USPSTF) guidelines here**	**American Cancer Society (ACS) guidelines here**	**Centers for Medicare and Medicaid Services (CMS) guidelines here & here**
Update Date	May 2021	2018	January 2021 and January 2023
Age	45-75	45-75	45-75
	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years – grade A The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years – grade B See the "Practice Considerations" section and Table 1 for details about screening strategies.	The American Cancer Society 2018 guideline for colorectal cancer screening recommends that average-risk adults aged 45 years and older undergo regular screening with either a high-sensitivity stool-based test or a structural (visual) exam, based on personal preferences and test availability. As a part of the screening process, all positive results on non-colonoscopy screening tests should be followed up with timely colonoscopy.	CMS allows coverage for the following: • Screening Colonoscopy (no minimum age limitation) The following screening tests that can be given beginning at age 45: • Flexible sigmoidoscopy (Healthcare Common Procedure Coding System (HCPCS) code G0104); • Guaiac-based fecal occult blood test (CPT 82270); • Immunoassay-based fecal occult blood test (HCPCS G0328); • Cologuard multi-target stool DNA test (CPT 81528); • Barium enema test (HCPCS codes G0106 [when administered as screening sigmoidoscopy alternative] and G0120 [when administered as screening colonoscopy alternative]); • Blood-based biomarker test (HCPCS code G0327)

Criteria	USPSTF	ACS	CMS
Frequency	High-sensitivity gFOBT or FIT annually; sDNA-FIT every 1 to 3 years; CT colonography every 5 years; Flexible sigmoidoscopy every 5 years; Flexible sigmoidoscopy every 10 years + FIT every year; Colonoscopy screening every 10 years.	Fecal immunochemical test annually; High-sensitivity, guaiac-based fecal occult blood test annually; Multitarget stool DNA test every 3 years; Colonoscopy every 10 years; Computed tomography colonography every 5 years; Flexible sigmoidoscopy every 5 years.	
Other criteria	The USPSTF concludes with moderate certainty that screening for colorectal cancer in adults aged 76 to 85 years who have been previously screened has small net benefit. Adults who have never been screened for colorectal cancer are more likely to benefit.	The recommendation to begin screening at age 45 years is a qualified recommendation. The recommendation for regular screening in adults aged 50 years and older is a strong recommendation. The ACS recommends (qualified recommendations) that: 1) average-risk adults in good health with a life expectancy of more than 10 years continue CRC screening through the age of 75 years; 2) clinicians individualize CRC screening decisions for individuals aged 76 through 85 years based on patient preferences, life expectancy, health status, and prior screening history; and 3) clinicians discourage individuals older than 85 years from continuing CRC screening.	A positive result from a non-invasive stool-based CRC screening test no longer requires that the following colonoscopy be a diagnostic colonoscopy. CRC screening tests now include a follow-on screening colonoscopy after a Medicare-covered, non-invasive, stool-based CRC screening test returns a positive result (within the context of a complete colorectal cancer screening). Both the non-invasive, stool-based test and the follow-on colonoscopy are both part of a continuum of a complete CRC screening.

Other criteria continued			**CMS** Patient cost sharing won't apply to the non-invasive, stool-based test and the follow-on screening colonoscopy in the scenario of a complete colorectal cancer screening, because both are specified preventive screening services. In addition, frequency limitations for screening colonoscopies in 42 CFR 410.37(g) won't apply to the follow-on screening colonoscopy in the context of a complete colorectal cancer screening. When a provider conducts a screening colonoscopy in the context of a complete colorectal cancer screening (following a positive result from a non-invasive stool-based CRC screening test), the providing practitioner must apply the -KX modifier to the claim for the screening colonoscopy to confirm that the clinical requirements of the complete colorectal cancer screening policy are met. The providing practitioner is responsible for correctly applying the -KX modifier to appropriate claims for screening colonoscopy in the context of a complete colorectal cancer screening.

Lung Cancer Screening Guidelines with low-dose computed tomography (LDCT): USPSTF, CMS, and ACS

Updated February 23, 2024

Developed by the QUILS™ Group

Criteria	**United States Preventive Services Task Force (USPSTF) guidelines here**	**Centers for Medicare and Medicaid Services (CMS) guidelines here**	**American Cancer Society (ACS) guidelines here** **Detailed manuscript here**
Update Date	March 9, 2021	February 10, 2022	November 1, 2023
Age	50-80	50-77	50-80
Smoking History	20 pack year smoking history	Tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes)	Have at least a 20 pack-year history of smoking
Smoking Status	Currently smoking or quit within the past 15 years	Currently smoking or quit within the last 15 years	Currently smoking or used to smoke. Recommend against using any duration of years since quitting smoking (YSQ) as a criterion to begin or end LCS in individuals who formerly smoked and who meet age and pack-year eligibility criteria.
Frequency	Annual screening	Annual screening	Annual screening
Comorbid Conditions	Stop screening if a person develops a health problem that substantially limits life expectancy or the ability/willingness to have curative lung surgery	Consider impact of comorbidities and ability or willingness to undergo diagnosis and treatment	Existing comorbid conditions that may limit life expectancy or the inability or unwillingness to undergo evaluation of positive screening findings or to undergo treatment are factors that should preclude referrals for screening.

Criteria	USPSTF	CMS	ACS
Tobacco Treatment	All people enrolled in a screening program who are currently smoking should receive smoking cessation interventions. Clinicians ask all adults about tobacco use, advise them to stop using tobacco, provide behavioral interventions and US Food and Drug Administration (FDA)--approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.	• Counseling on the importance of maintaining cigarette smoking abstinence if formerly smoked; or • The importance of smoking cessation if currently smoking; • and, if appropriate, furnishing information about tobacco cessation interventions.	Persons who currently smoke should be advised to quit and offered counseling and pharmacotherapy to assist with quitting.
Shared Decision Making	Benefit of screening varies with risk because persons at higher risk are more likely to benefit. Defines *shared decision making* as a particular process of decision making by the patient and clinician in which the patient: • Understands the risk or seriousness of the disease or condition to be prevented. • Understands the preventive service, including the risks, benefits, alternatives, and uncertainties. • Has weighed his or her values regarding the potential benefits and harms associated with the service. • Has engaged in decision making at a level at which he or she desires and feels comfortable.	Before the beneficiary's first lung cancer LDCT, must receive a counseling and shared decision-making visit that meets all the following criteria and appropriately documented in medical record: • Determination of beneficiary eligibility; • Shared decision-making, including the use of one or more decision aids; • Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment; and • Counseling on the importance of maintaining cigarette smoking abstinence if formerly smoking; or the importance of smoking cessation if currently smoking and, if appropriate, furnishing of information about tobacco cessation interventions.	Because of the comorbid considerations, the risks associated with LCS, and the relative newness of LCS to the target population, potentially eligible individuals should undergo a process of shared decision-making (SDM) that includes a discussion about the: • Purpose of LCS, • Consensus among leading organizations on recommendations endorsing LCS; • Screening process • Importance of regular screening; • Benefits, limitations, and potential harms of screening; and • Consideration of patient values and preferences.

Prostate Cancer Screening: USPSTF, ACS, and CMS *Table Updated April 19, 2024*			
Criteria	**United States Preventive Services Task Force (USPSTF) guidelines here**	**American Cancer Society (ACS) guidelines here**	**American Urological Association (AUA/SAO) guidelines here**
Update date	May 2018; Currently in Progress	November 2023	2023
Age	55-69	40-45 for high risk; 50 for average risk	40-45 high risk; 45-50 may begin; 50-69 every 2-4 years.
	For men aged 55 to 69 years, the decision to undergo periodic prostate-specific antigen (PSA)-based screening for prostate cancer should be an individual one. Before deciding whether to be screened, men should have an opportunity to discuss the potential benefits and harms of screening with their clinician and to incorporate their values and preferences in the decision.	The American Cancer Society recommends that men have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer. The decision should be made after getting information about the possible benefits, risks, and uncertainties of prostate cancer screening. The discussion about screening should take place at: • Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years • Age 45 for men at high risk of developing prostate cancer. This includes African American men and men who have a first-degree relative (father or brother) diagnosed with prostate cancer at an early age (younger than age 65). • Age 40 for men at even higher risk (those with more than one first-degree relative who had prostate cancer at an early age).	Clinicians should engage in shared decision-making (SDM) with people for whom prostate cancer screening would be appropriate and proceed based on a person's values and preferences. (Clinical Principle) When screening for prostate cancer, clinicians should use PSA as the first screening test. (Strong Recommendation; Evidence Level: Grade A) For people with a newly elevated PSA, clinicians should repeat the PSA prior to a secondary biomarker, imaging, or biopsy. (Expert Opinion) Clinicians may begin prostate cancer screening and offer a baseline PSA test to people between ages 45 to 50 years. (Conditional Recommendation; Evidence Level: Grade B)

Criteria	USPSTF	ACS	AUO/SAO
Age	55-69	40-45 for high risk; 50 for average risk	40-45 high risk; 45-50 may begin; 50-69 every 2-4 years.
	Screening offers a small potential benefit of reducing the chance of death from prostate cancer in some men. However, many men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and erectile dysfunction. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms based on family history, race/ethnicity, comorbid medical conditions, patient values about the benefits and harms of screening and treatment-specific outcomes, and other health needs. Clinicians should not screen men who do not express a preference for screening.		Clinicians should offer prostate cancer screening beginning at age 40 to 45 years for people at increased risk of developing prostate cancer based on the following factors: Black ancestry, germline mutations, strong family history of prostate cancer. (Strong Recommendation; Evidence Level: Grade B) Clinicians should offer regular prostate cancer screening every 2 to 4 years to people aged 50 to 69 years. (Strong Recommendation; Evidence Level: Grade A)

Criteria	USPSTF	ACS	AUO/SAO
Frequency	No specific frequency included; emphasis on informed decision making	If no prostate cancer is found as a result of screening, the time between future screenings depends on the results of the PSA blood test: • Men who choose to be tested who have a PSA of less than 2.5 ng/mL may only need to be retested every 2 years. • Screening should be done yearly for men whose PSA level is 2.5 ng/mL or higher.	Every 2-4 years for people age 50-69 years. Clinicians may personalize the re-screening interval, or decide to discontinue screening, based on patient preference, age, PSA, prostate cancer risk, life expectancy, and general health following SDM. *(Conditional Recommendation; Evidence Level: Grade B)*
Other criteria	The USPSTF recommends against PSA-based screening for prostate cancer in men 70 years and older.	Because prostate cancer often grows slowly, men without symptoms of prostate cancer who have less than a 10-year life expectancy should not be offered prostate cancer screening, because they aren't likely to benefit from it. Overall health status, and not age alone, is important when making decisions about screening. Even after a decision about testing has been made, the discussion about the pros and cons of testing should be repeated as new information about the benefits and risks of testing becomes available. Further discussions are also needed to take into consider changes in a man's health, values, and preferences.	Clinicians may use digital rectal exam (DRE) alongside PSA to establish risk of clinically significant prostate cancer. (*Conditional Recommendation; Evidence Level: Grade C*) For people undergoing prostate cancer screening, clinicians should not use PSA velocity as the sole indication for a secondary biomarker, imaging, or biopsy. (*Strong Recommendation; Evidence Level: Grade B*) Clinicians and patients may use validated risk calculators to inform the SDM process regarding prostate biopsy. (*Conditional Recommendation; Evidence Level: Grade B*)

Criteria	USPSTF	ACS	AUO/SAO
Other criteria continued			When the risk of clinically significant prostate cancer is sufficiently low based on available clinical, laboratory, and imaging data, clinicians and patients may forgo near-term prostate biopsy. (*Clinical Principle*) Clinicians should inform patients undergoing a prostate biopsy that there is a risk of identifying a cancer with a sufficiently low risk of mortality that could safely be monitored with active surveillance (AS) rather than treated. (*Clinical Principle*) See additional guidance on biopsy guidance and technique here.