Colorectal Cancer Screening

Overview

Primarily affecting men and women ages 50 and older, colorectal cancer is the third leading cause of cancer deaths in the United States. The risk of developing the disease increases with age.[1] Patients with colorectal cancer rarely display any symptoms, and the cancer can progress unnoticed and untreated until it becomes fatal. The most common symptom of colorectal cancer is bleeding from the rectum. Other common symptoms include cramps, abdominal pain, intestinal obstruction, or a change in bowel habits.

Colorectal cancer is largely preventable through screening, which can find pre-cancerous polyps (growths in the colon) that can be removed before they develop into cancer. Screening can also detect cancer early when it is easier to treat and cure. Screenings are performed to diagnose or determine a beneficiary's risk for developing colorectal cancer. Colorectal cancer screening may consist of several different screening services to test for polyps or colorectal cancer. Each colorectal cancer screening can be used alone or in combination with each other.

Medicare's colorectal cancer screening benefit was created as a result of the implementation of the Balanced Budget Act of 1997 (BBA). Medicare began coverage of colorectal cancer screening services on January 1, 1998 for the early detection of colorectal cancer. The BBA provided coverage for various colorectal cancer screening examinations subject to certain coverage, frequency, and payment limitations. Subsequent legislation expanded the colorectal screening benefit to include colonoscopies for Medicare beneficiaries not at high risk for developing colorectal cancer and amended the conditions for payment for a screening sigmoidoscopy.

Medicare provides coverage of the following colorectal cancer screening services for the early detection of colorectal cancer:

- Fecal Occult Blood Test (FOBT),
- Flexible Sigmoidoscopy,
- Colonoscopy, and
- Barium Enema (as an alternative to a covered screening flexible sigmoidoscopy or a screening colonoscopy).

NOTE: At this time, Medicare does not cover screening Deoxyribonucleic Acid (DNA) stool tests as part of the colorectal cancer screening benefit.

The **Fecal Occult Blood Test** checks for occult or hidden blood in the stool. A Medicare provider gives a FOBT card to the beneficiary, and the beneficiary can perform the test at home. The beneficiary takes stool samples and places them on the test cards and then returns them to the doctor or a laboratory. The FOBT consists of either one of two types of tests:

1. Fecal Occult Blood Test, 1-3 Simultaneous Determinations -- A guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools.

1 The American Cancer Society, Inc. 2008. What Are the Key Statistics for Colorectal Cancer? [online]. Atlanta, GA: The American Cancer Society, Inc., 18 March 2009 [cited 22 June 2009]. Available from the World Wide Web: (http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_colon_and_rectum_cancer.asp?sitearea=).

OR

2. Immunoassay, Fecal Occult Blood Test, 1-3 Simultaneous Determinations -- An immunoassay (or immunochemical) test for antibody activity in which the beneficiary completes the test by taking the appropriate number of samples according to the specific manufacturer's instructions.

The **Flexible Sigmoidoscopy** is a procedure used to check for polyps and cancer. It is administered using a thin, flexible, lighted tube called a sigmoidoscope that provides direct visualization of the rectum and lower third of the colon. The procedure allows for biopsies of polyps and cancers to be taken as well as polyp removal.

The **Colonoscopy** is a procedure similar to the flexible sigmoidoscopy, except a longer, thin, flexible, lighted tube called a colonoscope is used to provide direct visualization of the rectum and the entire colon. This procedure is used to check for polyps and cancer in the rectum and the entire colon. Most polyps and some cancers can be found and removed during the procedure.

The **Barium Enema** is a procedure in which the beneficiary is given an enema with barium. The X-ray images are taken of the rectum and entire colon that allows the physician to see the outline of the beneficiary's colon to check for polyps or other abnormalities.

Risk Factors

Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- 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, or
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

Coverage Information

Medicare provides coverage of colorectal cancer screening for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema rendered as an alternative to a screening colonoscopy.

Medicare provides coverage for colorectal cancer screening as a Medicare Part B benefit. The beneficiary will pay nothing for the FOBT (there is no deductible and no coinsurance or copayment for this benefit). For all other procedures, the coinsurance or copayment applies; however, there is no deductible.

NOTE: Medicare does not waive the deductible if the colorectal cancer screening test becomes a diagnostic colorectal test; that is, the service actually results in a biopsy or removal of a lesion or growth.

If the flexible sigmoidoscopy or colonoscopy procedure is performed in a hospital outpatient department or in an ambulatory surgical center, the beneficiary will pay 25 percent of the Medicare-approved amount.

The following are the coverage criteria for each colorectal cancer screening test/procedure.

Screening Fecal Occult Blood Test (HCPCS G0328 and CPT 82270)

Medicare provides coverage of a screening FOBT annually (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed) for beneficiaries age 50 and older. This screening requires a written order from the beneficiary's attending physician.

NOTE: Payment may be made for an immunoassay-based FOBT [Healthcare Common Procedure Coding System (HCPCS) code (G0328)] as an alternative to the guaiac-based FOBT [Common Procedural Terminology (CPT) code (82270)]. However, Medicare will only provide coverage for one FOBT per year, either CPT code 82270 or HCPCS code G0328, but not both.

Who Can Order the Screening Fecal Occult Blood Test?

The screening FOBT requires a written order from the beneficiary's attending physician. Attending physician means a doctor of medicine or osteopathy who is fully knowledgeable about the beneficiary's medical condition and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

Screening Flexible Sigmoidoscopy (HCPCS G0104)

Medicare provides coverage of a screening flexible sigmoidoscopy for beneficiaries age 50 or older, without regard to risk.

Who Can Perform a Screening Flexible Sigmoidoscopy?

Screening flexible sigmoidoscopies must be performed by a doctor of medicine or osteopathy, or by a physician assistant, nurse practitioner, or clinical nurse specialist.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening flexible sigmoidoscopy once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for beneficiaries at high risk for colorectal cancer.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening flexible sigmoidoscopy once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for beneficiaries age 50 and older **unless** the beneficiary does not meet the high risk criteria for developing colorectal cancer **and** the beneficiary has had a screening colonoscopy (HCPCS code G0121) within the preceding 10 years. If the beneficiary has had a screening colonoscopy within the preceding 10 years, then the next screening flexible sigmoidoscopy will be covered only after at least 119 months have passed following the month in which the last covered screening colonoscopy (HCPCS code G0121) was performed.

NOTE: If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed rather than code HCPCS code G0104.

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Screening Colonoscopy (HCPCS codes G0105 and G0121)

Medicare provides for coverage of a screening colonoscopy for all beneficiaries without regard to age. A doctor of medicine or osteopathy must perform this screening.

Who Can Perform a Screening Colonoscopy?

Screening colonoscopies must be performed by a doctor of medicine or osteopathy.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening colonoscopy (HCPCS code G0105) once every 2 years for beneficiaries at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered HCPCS code G0105 screening colonoscopy was performed).

NOTE: If during the course of the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed rather than code HCPCS code G0105.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening colonoscopy (HCPCS code G0121) for beneficiaries who do not meet the criteria for being at high risk for developing colorectal cancer, under the following conditions:

- At a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered HCPCS code G0121 screening colonoscopy was performed).
- If the beneficiary otherwise qualifies to have a covered screening colonoscopy (HCPCS code G0121) based on the above **but** has had a covered screening flexible sigmoidoscopy (HCPCS code G0104), then Medicare may cover a screening colonoscopy (HCPCS code G0121) only after at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy (HCPCS code G0104) was performed.

NOTE: If during the course of the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed rather than code HCPCS code G0121.

Screening Barium Enema (HCPCS codes G0106 and G0120)

Medicare provides coverage of a screening barium enema examination as an alternative to either a high risk screening colonoscopy (HCPCS code G0105) or a screening flexible sigmoidoscopy (HCPCS code G0104).

Who Can Order a Screening Barium Enema?

The screening barium enema must be ordered by a doctor of medicine or osteopathy.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening barium enema (HCPCS code G0120), as an alternative to a screening colonoscopy (HCPCS code G0105), every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening barium enema or the last screening colonoscopy was performed) for beneficiaries at high risk for colorectal cancer, without regard to age. The same frequency parameters for screening colonoscopies apply.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening barium enema (HCPCS code G0106), as an alternative to a screening flexible sigmoidoscopy (HCPCS code G0104), once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening barium enema or screening flexible sigmoidoscopy was performed) for beneficiaries not at high risk for colorectal cancer, but who are age 50 or older. The same frequency parameters for screening sigmoidoscopies apply.

The screening barium enema (preferably a double contrast barium enema) must be ordered in writing after a determination that the procedure is appropriate. If the individual cannot withstand a double contrast barium enema, the attending physician may order a single contrast barium enema. The attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the estimated screening potential for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, for the same individual. The screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described previously for the screening double contrast barium enema examination.

Documentation

Documentation in the beneficiary's medical record must identify any risk factors for tests/procedures performed.

When a covered procedure is attempted and unable to be completed, Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event the Medicare Contractor needs the information to document the incomplete procedure.

If a screening barium enema is provided, the documentation should reflect that the procedure was performed:

- As an alternative to either a screening flexible sigmoidoscopy or a high risk screening colonoscopy, and
- Because it is determined that the screening potential for the barium enema is equal to or greater than the estimated screening potential for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, for the same individual.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS)/Common Procedural Terminology (CPT) codes listed in Table 1 to report colorectal cancer screening services:

Table 1 – HCPCS/CPT Codes for Colorectal Screening Services

HCPCS/CPT Code	Code Descriptor
G0104	Colorectal cancer screening; flexible sigmoidoscopy
G0105	Colorectal cancer screening; colonoscopy on individual at high risk

HCPCS/CPT Code	Code Descriptor
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
G0107*	Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0122	Colorectal cancer screening; barium enema
G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous

***NOTE:** For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report G0107.

Non-Covered Colorectal Cancer Screening Services

Medicare covers colorectal barium enemas only in lieu of covered screening flexible sigmoidoscopies (HCPCS code G0104) or covered screening colonoscopies (HCPCS code G0105). However, there may be instances when the beneficiary has elected to receive the barium enema for colorectal screening other than specifically for these purposes. In such situations, the beneficiary may require a formal denial of the service from Medicare in order to bill a supplemental insurer who may cover the service. These non-covered barium enemas are to be identified by HCPCS code G0122 (colorectal cancer screening; barium enema). Medicare providers should not use HCPCS code G0122 for covered barium enema services, that is, those rendered in place of the covered screening colonoscopy or covered flexible sigmoidoscopy. The beneficiary is liable for payment of the non-covered barium enema.

Diagnosis Requirements

For the screening colonoscopy, the beneficiary is not required to have any present signs/symptoms. However, when Medicare providers bill for the "high risk" beneficiary, the screening diagnosis code on the claim must reflect at least one of the high risk conditions described previously.

Listed in Table 2, Table 3, and Table 4 are examples of diagnoses that meet high risk criteria for colorectal cancer. **This is not an all-inclusive list.** There may be more instances of conditions that could be coded and would be applicable.

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Table 2 – Personal History ICD-9-CM Codes

ICD-9-CM Code	Code Descriptor
V10.05	Personal history of malignant neoplasm of large intestine
V10.06	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

Table 3 – Chronic Digestive Disease Condition ICD-9-CM Codes

ICD-9-CM Code	Code Descriptor
555.0	Regional enteritis of small intestine
555.1	Regional enteritis of large intestine
555.2	Regional enteritis of small intestine with large intestine
555.9	Regional enteritis of unspecified site
556.0	Ulcerative (chronic) enterocolitis
556.1	Ulcerative (chronic) ileocolitis
556.2	Ulcerative (chronic) proctitis
556.3	Ulcerative (chronic) proctosigmoiditis
556.8	Other ulcerative colitis
556.9	Ulcerative colitis, unspecified

Table 4 – Inflammatory Bowel ICD-9-CM Codes

ICD-9-CM Code	Code Descriptor
558.2	Toxic gastroenteritis and colitis
558.9	Other and unspecified noninfectious gastroenteritis and colitis

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT codes and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit those claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT codes, the appropriate revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit those claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for colorectal cancer screening when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 5:

Table 5 – Facility Types, Types of Bills, and Revenue Codes for Colorectal Cancer Screening Services

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	See Table 6
Hospital Non-patient Laboratory Specimens	14X**	030X (HCPCS/CPT 82270 and G0328 only)

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Facility Type	Type of Bill	Revenue Code
Skilled Nursing Facility (SNF) Inpatient Part B	22X	See Table 7
SNF Outpatient	23X	See Table 7
Ambulatory Surgical Center (ASC)	83X	030X for HCPCS/CPT 82270, G0328 The appropriate revenue code when reporting any other surgical procedure for HCPCS G0104, G0105, G0121
Critical Access Hospital (CAH)*	85X	See Table 6

***NOTE:** Method I – All technical components are paid using standard institutional billing practices.

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X. For the technical or facility component, use revenue code 075X or another appropriate revenue code.

****NOTE:** All hospitals submitting claims containing CPT code 82270 and HCPCS code G0328 for non-patient laboratory specimens should use TOB 14X.

Table 6 – Procedure, Revenue Code, and Associated HCPCS/CPT Codes for Facilities Using Types of Bills 13X, 83X, and 85X

Screening Test/Procedure	Revenue Code	HCPCS/CPT Code
Fecal Occult Blood Test	030X	82270, G0107*, G0328
Barium Enema	032X	G0106, G0120 (G0122 non-covered)
Flexible Sigmoidoscopy	The appropriate revenue code when reporting any other surgical procedure for bill types 13X, 83X, or 85X	G0104
Colonoscopy-High Risk	The appropriate revenue code when reporting any other surgical procedure for bill types 13X, 83X, or 85X	G0105, G0121

***NOTE:** For claims with dates of service **prior** to January 1, 2007, physicians, suppliers, and providers report G0107.

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NOTE: Hospital and Critical Access Hospital (CAH) providers should submit TOBs 13X or 85X. Outpatient surgery performed by a hospital not bound by the Outpatient Prospective Payment System (OPPS) requirements should submit TOB 83X.

Special Billing Instructions for Hospital Inpatients

When these tests/procedures are provided to inpatients of a hospital, the inpatients are covered under this benefit. However, the Medicare provider should bill on TOB 13X using the discharge date of the hospital stay to avoid editing.

See the National Correct Coding Initiative Edits web page for currently applicable bundled carrier processed procedures at http://www.cms.hhs.gov/NationalCorrectCodInitEd on the CMS website.

Special Billing Instructions for Skilled Nursing Facilities (SNFs)

When colorectal cancer screening tests are provided to inpatients of a SNF, the Medicare provider should bill the test on TOB 22X using the actual date of service.

Table 7 – Procedure, Revenue Code, and Associated HCPCS/CPT Codes for SNFs

Screening Test/Procedure	Revenue Code	HCPCS/CPT Code
Fecal Occult Blood Test	030X	82270, G0107*
Fecal Occult Blood Test, Immunoassay	030X	G0328
Barium Enema	032X	G0106, G0120 (G0122 non-covered)
Flexible Sigmoidoscopy	The appropriate revenue code when reporting any other surgical procedure	G0104, G0105, G0121

***NOTE:** For claims with dates of service **prior** to January 1, 2007, physicians, suppliers, and providers report G0107.

Reimbursement Information

General Information

There is no Medicare Part B deductible or coinsurance/copayment for the FOBT. For all other colorectal screening tests, there is no deductible. Coinsurance or copayments apply.

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Payment of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare makes payment to physicians for colorectal screening procedures under the Medicare Physician Fee Schedule (MPFS) when billed to the carrier/AB MAC. Medicare makes payment to ambulatory surgical centers (ASCs) for facility services furnished in connection with colorectal screening procedures (included on the ASC list of covered surgical procedures) under the ASC fee schedule when billed to the carrier/AB MAC. Coinsurance or copayment applies. (The beneficiary coinsurance for the ASC facility fee is 25 percent of the ASC fee schedule payment amount.) Beginning January 1, 2007, there is no deductible for colorectal cancer screening tests.

Additional information about the MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Additional information about the Clinical Laboratory Fee Schedule can be found at http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Additional information about OPPS can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS on the CMS website.

NOTE: Medicare does not waive the deductible if the colorectal cancer screening test becomes a diagnostic colorectal test; that is, the service results in a biopsy or removal of a lesion or growth.

Reimbursement for FOBTs is paid under the Clinical Laboratory Fee Schedule, with the exception of CAHs, which are paid on a reasonable cost basis. Deductible and coinsurance do not apply for this type of screening.

Payment by Carriers/AB MACs of Interrupted and Completed Colonoscopies

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay the physician for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy, as long as coverage conditions are met for the incomplete procedure. When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with modifier -53 to indicate that the procedure was interrupted.

When a covered colonoscopy is attempted in an ASC and is discontinued due to extenuating circumstances that threaten the well-being of the patient prior to the administration of anesthesia, but after the beneficiary has been taken to the procedure room, the ASC is to suffix the colonoscopy code with modifier -73 and payment will be reduced by 50 percent. If the colonoscopy is begun (e.g., anesthesia administered, scope inserted, incision made) but is discontinued due to extenuating circumstances that threaten the well-being of the patient, the ASC is to suffix the colonoscopy code with modifier -74 and the procedure will be paid at the full amount.

Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event that the Medicare Contractor needs it to document the incomplete procedure.

When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met. This policy is applied to both screening and diagnostic colonoscopies.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for colorectal cancer screening procedures is dependent upon the type of facility providing the service. Table 8 lists the type of payment that facilities receive for colorectal screening services:

Table 8 – Types of Payments Received by Facilities for Colorectal Cancer Screening Services

Type of Colorectal Screening	Facility	Type of Payment	Deductible/Coinsurance
Fecal Occult Blood Tests (82270, G0328, and G0107*)	CAH	Reasonable Cost Basis	Deductible and coinsurance do not apply for this type of screening.
Fecal Occult Blood Tests (82270, G0328, and G0107*)	All other types of facilities	Clinical Laboratory Fee Schedule (Medicare pays 100% of the Clinical Laboratory Fee Schedule amount or the provider's actual charge, whichever is lower.)	Deductible and coinsurance do not apply for this type of screening.
Flexible Sigmoidoscopy (G0104)	CAH	Reasonable Cost Basis	Deductible does not apply. Coinsurance applies for this type of screening, with one exception: For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount.
Flexible Sigmoidoscopy (G0104)	Hospital Outpatient Departments	Outpatient Prospective Payment System (OPPS)	Deductible does not apply. Coinsurance applies for this type of screening, with one exception: For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount.
Flexible Sigmoidoscopy (G0104)	SNF Inpatient (for Medicare Part B Services)	Medicare Physician Fee Schedule (MPFS)	Deductible does not apply. Coinsurance applies for this type of screening, with one exception: For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount.

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Type of Colorectal Screening	Facility	Type of Payment	Deductible/Coinsurance
Colonoscopy (G0105 and G0121)	CAH	Reasonable Cost Basis	Deductible does not apply. Coinsurance apply for this type of screening, with the exception of the following: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure. For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount.
Colonoscopy (G0105 and G0121)	Hospital Outpatient Departments	OPPS	Deductible does not apply. Coinsurance apply for this type of screening, with the exception of the following: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure. For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount.
Barium Enemas (G0106 and G0120)	CAH	Reasonable Cost Basis	Deductible does not apply. Coinsurance apply for this type of screening, with one exception: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure.
Barium Enemas (G0106 and G0120)	Hospital Outpatient Departments	OPPS	Deductible does not apply. Coinsurance apply for this type of screening, with one exception: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure.

Type of Colorectal Screening	Facility	Type of Payment	Deductible/Coinsurance
Barium Enemas (G0106 and G0120)	SNF	MPFS	Deductible does not apply. Coinsurance apply for this type of screening, with one exception: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure.

In addition, the colorectal cancer screening codes must be paid at rates consistent with the colorectal diagnostic codes.

***NOTE:** For claims with dates of service **prior** to January 1, 2007, physicians, suppliers, and providers report G0107.

NOTE: Beginning January 1, 2008, colorectal cancer screening sigmoidoscopies (G0104) are payable in ASCs. The deductible does not apply for the screening and the beneficiary pays 25 percent of the Medicare-approved amount.

Payment by FIs/AB MACs of Interrupted and Completed Colonoscopies

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy as long as the coverage conditions are met for the incomplete procedure. The Common Working File (CWF) will not apply the frequency standards associated with screening colonoscopies. When submitting a facility claim for the interrupted colonoscopy, providers are to suffix the colonoscopy HCPCS codes with modifier -73 or -74, as appropriate, to indicate that the procedure was interrupted. Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event that the Medicare Contractor needs it to document the incomplete procedure.

When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure, as long as coverage conditions are met. The frequency standards will be applied by the CWF. This policy is applied to both screening and diagnostic colonoscopies.

Critical Access Hospital (CAH) Payment by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs) of Interrupted and Completed Colonoscopies

In situations where a CAH has elected payment Method II for CAH beneficiaries, payment should be consistent with payment methodologies currently in place. As such, CAHs that elect Method II should use payment modifier -53 to identify an incomplete screening colonoscopy [physician professional service(s) billed with revenue code 096X, 097X, and/or 098X]. Such CAHs will also bill the technical or facility component of the interrupted colonoscopy in revenue code 075X (or other appropriate revenue code) using modifier -73 or -74, as appropriate.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of colorectal cancer screening:

- The beneficiary is under age 50.
- The beneficiary does not meet the criteria of being at high risk of developing colorectal cancer.
- The beneficiary has exceeded Medicare's frequency parameters for coverage of colorectal cancer screening services.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Colorectal Cancer Screening

Resource Materials

The American Cancer Society
Website offers free materials to help clinicians encourage colorectal cancer screening among patients 50 and older. Includes a toolbox, "How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide," for primary care clinicians that outlines an efficient way to get every patient in for the colorectal cancer screening tests he or she needs.
http://www.cancer.org/docroot/PRO/PRO_4_ColonMD.asp

The American Cancer Society's ACS Cancer Facts & Figures 2008
http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Clinical Laboratory Fee Schedule Information
http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Medicare Benefit Policy Manual – Pub.100-02, Chapter 15, Section 280.2
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 60
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule and OPPS.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Beneficiary-related resources can be found in Reference F of this Guide.

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Matters Articles
http://www.cms.hhs.gov/MLNMattersArticles

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

The National Cancer Institute's Colorectal Cancer Prevention
http://www.nci.nih.gov/cancertopics/pdq/prevention/colorectal/Patient/page2

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

Outpatient Prospective Payment System Information
http://www.cms.hhs.gov/HospitalOutpatientPPS

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

What Are the Key Statistics for Colorectal Cancer?
A colorectal cancer fact sheet produced by the American Cancer Society.
http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_colon_and_rectum_cancer.asp?sitearea=

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