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**News Flash** - Test Your Medicare Claims Now! After you have submitted claims containing both NPIs and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with only the NPI in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch. (Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)

## Colorectal Cancer: Preventable, Treatable, and Beatable: Medicare Coverage and Billing for Colorectal Cancer Screening

### Provider Types Affected

Physicians, nurse practitioners, physician assistants, clinical nurse specialists, outpatient hospital departments, community surgical centers

### Provider Action Needed



#### STOP – Impact to You

March is National Colorectal Cancer Awareness Month. The Centers for Medicare & Medicaid Services (CMS) would like to remind providers to encourage their eligible Medicare patients ages 50 and older to get screened for colorectal cancer. This MLN Matters Special Edition issue reviews Medicare coverage and billing processes for colorectal cancer screening.

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This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

**CAUTION – What You Need to Know**

Medicare has covered colorectal cancer screening since 1998, but the benefit is underused. Claims data from 1998-2002 indicate that less than half of Medicare beneficiaries had any screening test during this five-year period, and less than one-third were tested according to recommended intervals.

**GO – What You Need to Do**

Encourage your patients to be screened, appropriately bill Medicare for the screening test you provide, and follow up with patients, as needed.

## Background

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Colorectal cancer is the second leading cause of cancer death in the United States and the third most common type of cancer. In 2005, colorectal cancer was expected to account for 56,290 deaths and 145,290 new cases. Colorectal cancer primarily affects men and women ages 50 and older, and risk increases with age. If detected early, colorectal cancer can be treated and cured.

In January 1998, Medicare began covering colorectal cancer screening. The data currently available (1998 - 2002) indicates that the colorectal cancer screening benefit is underused. Less than half of enrollees had any colorectal cancer test during the five-year period and less than one-third were tested according to recommended intervals.

The U.S. Preventive Services Task Force (USPSTF) evaluates the clinical merits of preventive measures, and strongly recommends ("A" rating) that clinicians screen men and women ages 50 and older for colorectal cancer. The choice of screening strategy should be based on patient preferences, medical contraindications, patient adherence, and resources for testing and follow-up. To read the full recommendation, go to

<http://www.ahrq.gov/clinic/uspstf/uspscolo.htm> on the Internet.

The Partnership for Prevention conducted a systematic assessment of the clinical preventive services recommended by the USPSTF to help decision-makers identify those services that provide the most value based on two criteria—burden of disease prevented and cost-effectiveness. Screening adults for colorectal cancer screening was among the services considered to be of the greatest value.

### *Colorectal Cancer Screening Methods*

There are a variety of methods available for colorectal cancer screening, including fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, and screening

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barium enema. It is important that practitioners follow the practice guidelines for screening and follow-up.

Two studies published in January 2005 in the *Annals of Internal Medicine* suggest that the office-based single sample screening fecal occult blood test is of limited value, and that many physicians are not following practice guidelines for screening and follow-up. Click on the following link for information on colorectal cancer detection and American Cancer Society screening recommendations and guidelines:

[http://www.cancer.org/docroot/CRI/content/CRI\\_2\\_6X\\_Colorectal\\_Cancer\\_Early\\_Detection\\_10.asp?sitearea=&level](http://www.cancer.org/docroot/CRI/content/CRI_2_6X_Colorectal_Cancer_Early_Detection_10.asp?sitearea=&level) on the Internet.

## Coverage

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Medicare covers the following colorectal cancer screening tests and procedures:

### ***Fecal Occult Blood Test (FOBT)***

Medicare covers one FOBT annually for beneficiaries 50 and older. A written order from the beneficiary's attending physician is required. Medicare will pay for an immunoassay-based FOBT as an alternative to the guaiac-based FOBT, but will only pay for one FOBT, not both, per year.

Beneficiaries do not have to pay coinsurance for the FOBT, and don't have to meet the annual Medicare Part B deductible.

### ***Screening Flexible Sigmoidoscopy***

Medicare covers a screening flexible sigmoidoscopy once every four years for beneficiaries 50 and older. If a beneficiary had a screening colonoscopy in the previous 10 years, then the next screening flexible sigmoidoscopy would be covered only after 119 months have passed following the month in which the last screening colonoscopy was performed. A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist may perform a screening flexible sigmoidoscopy.

### ***Screening Colonoscopy***

Medicare coverage for a screening colonoscopy is based on beneficiary risk.

- For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every 10 years, but not within 47 months of a previous screening flexible sigmoidoscopy.
- For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every two years, regardless of age.

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A screening colonoscopy must be ordered and provided by a doctor of medicine or osteopathy.

### *Screening Barium Enema*

Medicare covers a screening barium enema as an alternative to a screening flexible sigmoidoscopy or a screening colonoscopy.

- For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening barium enema every four years.
- For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers one screening barium enema every two years regardless of age.

A screening barium enema must be ordered in writing and provided by a doctor of medicine or osteopathy once it is determined that it is the appropriate screening method for a beneficiary. A double contrast barium enema is preferable, but the physician may order a single contrast barium enema if it is more appropriate for the beneficiary.

**Prior to January 1, 2007**, the beneficiary is liable for paying 20% of the Medicare-approved amount (the coinsurance) for screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema after meeting the annual Medicare Part B deductible.

For a screening flexible sigmoidoscopy or a screening colonoscopy performed in a hospital outpatient department, the beneficiary is liable for paying the Medicare-approved amount (the coinsurance) after meeting the annual Medicare Part B deductible.

**Effective January 1, 2007**, Medicare will waive the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS codes: G0104, G0105, G0121, G0106, and G0120. (This change is implemented under CR 5127, transmittal 1004, dated July 21, 2006.) While the deductible will be waived, and will not apply for colorectal cancer screening test services furnished on or after January 1, 2007, the Medicare Part B coinsurance still applies for these screening tests. In addition, effective January 1, 2007, Medicare requires a 25% beneficiary coinsurance. (This change is implemented under CR 5387, transmittal 1160, dated January 19, 2007.)

Beneficiaries are considered to be at high risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;

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- A family history of adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer;
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

## How to Bill Medicare

The following Healthcare Common Procedure Coding System (HCPCS) codes should be used to bill for colorectal cancer screening:

HCPCS Code	HCPCS Code Descriptor
G0104	Colon cancer screening; flexible sigmoidoscopy
G0105*	Colon cancer screening; colonoscopy on individual at high risk
G0106	Colon cancer screening; barium enema as an alternative to G0104
G0107	Colon cancer screening; FOBT, 1-3 simultaneous determinations
G0120	Colon cancer screening; barium enema as an alternative to G0105
G0121	Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk
G0122**	Colon cancer screening; barium enema (non-covered)
G0328	Colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations

\* When billing for the "high risk" beneficiary, the screening diagnosis code on the claim must reflect at least one of the high risk conditions mentioned previously. Examples of diagnostic codes are in the colorectal cancer screening chapter (page 81) of the Guide to Preventive Services. This guide is available at <http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf> on the CMS website.

\*\*Code G0122 should be used when a screening barium enema is performed **not** as an alternative to either to G0104 or G0105. This service is denied as non-covered because it fails to meet the requirements of the benefit. **The beneficiary is liable for payment.** Reporting of this non-covered code will also allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes.

If billing Medicare carriers, the appropriate HCPCS and corresponding diagnosis codes must be provided on Form CMS-1500 (or the HIPAA 837 Professional electronic claim record).

If billing Medicare intermediaries, the appropriate HCPCS, revenue, and corresponding diagnosis codes must be provided on Form CMS-1450 (or the HIPAA Institutional electronic claim record). Information on the type of bill and

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associated revenue code is also provided in the colorectal cancer screening Chapter (page 82) of the Guide to Preventive Services. This guide is available at <http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf> on the CMS website. Reimbursement information is also provided in this guide.

## Other Helpful Information

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CMS has developed a comprehensive prevention website that provides information and resources for all Medicare preventive benefits. The following link is to the colorectal cancer screening section, and includes website links to information and resources developed by other organizations interested in promoting colorectal cancer screening, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American Cancer Society: <http://www.cms.hhs.gov/ColorectalCancerScreening/> on the CMS website.

Also, visit the CMA preventive services website at [http://www.cms.hhs.gov/PrevntionGenInfo/01\\_Overview.asp#TopOfPage](http://www.cms.hhs.gov/PrevntionGenInfo/01_Overview.asp#TopOfPage) to access the *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* as well as other educational resources designed for health care professionals to promote and increase national awareness of Medicare-covered preventive services. Once on the MLN site, scroll to the bottom of the page and click on Products, then click on Preventive Services.

## Additional Information

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Additional related articles and Change Requests that providers may review are:

- MM5127 (Non-Application of Deductible for Colorectal Cancer Screening Tests) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf> and the related CR is at <http://www.cms.hhs.gov/Transmittals/downloads/R1004CP.pdf>;
- SE0746 (Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscopy) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0746.pdf>; and
- MM5387 (Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf> and the related CR is at <http://www.cms.hhs.gov/Transmittals/downloads/R1160CP.pdf> on the CMS website.

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