

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1062	Date: SEPTEMBER 22, 2006
	Change Request 5292

SUBJECT: Termination of Healthcare Common Procedure Coding System (HCPCS) Code G0107, Colorectal Cancer Screening, Fecal Occult Blood Test (FOBT), 1-3 Simultaneous Determinations

I. SUMMARY OF CHANGES: HCPCS code G0107 will be retired at the next annual release of the clinical diagnostic lab fee schedule effective January 1, 2007, and replaced with current procedural terminology (CPT) code 82270.

New/Revised Material

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/60/60.1/Payment
R	18/60/60.2/HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable)
R	18/60/60.2.1/Common Working Files (CWF) Edits
R	18/60/60.6/Billing Requirements for Claims Submitted to FIs
R	18/60/60.7/MSN Messages

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1062	Date: September 22, 2006	Change Request 5292
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SUBJECT: Termination of Healthcare Common Procedure Coding System (HCPCS) Code G0107, Colorectal Cancer Screening, Fecal-Occult Blood Tests (FOBT), 1-3 Simultaneous Determinations

I. GENERAL INFORMATION

A. Background: HCPCS code G0107 (Colorectal Cancer Screening; fecal-occult blood test, 1-3 simultaneous determinations) is currently being used for Medicare billing and payment of screening FOBT. HCPCS code G0107 will be retired effective January 1, 2007. It will be replaced for Medicare billing purposes by Current Procedural Terminology (CPT) code 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 three cards or single triple card for consecutive collection)). Prior to January 1, 2007, both codes were in the HCPCS data set, but Medicare only recognized HCPCS code G0107 for billing and payment of screening FOBT. Effective on or after January 1, 2007, CPT code 82270 will be used for billing and payment purposes by Medicare for screening FOBT. Therefore, when billing for FOBT screening services for claims with dates of service December 31, 2006 and earlier, physicians, suppliers and providers should use HCPCS code G0107; when billing for FOBT screening services for claims with dates of service January 1, 2007 and later, physicians, suppliers and providers should use CPT code 82270.

B. Policy: Effective for claims with dates of service January 1, 2007 and later, physicians, suppliers and providers shall report current CPT code 82270 in place of HCPCS code G0107 when billing for screening FOBT.

II. BUSINESS REQUIREMENTS

“Shall” denotes a mandatory requirement

“Should” denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5292.1	Contractors shall advise physicians, suppliers and providers that HCPCS code G0107 is being deleted from the clinical diagnostic laboratory fee schedule effective for claims with dates of service January 1, 2007.	X		X						A/B MAC

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5292.6	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: January 1, 2007</p> <p>Implementation Date: January 2, 2007</p> <p>Pre-Implementation Contact(s):</p> <p>Bill Ruiz (FIs) 410-786-9283 william.ruiz@cms.hhs.gov</p> <p>Maria Durham (FIs) 410-786-6978 maria.durham@cms.hhs.gov</p> <p>Susan Webster (Carriers) 410-786-3384 susan.webster@cms.hhs.gov</p> <p>Post-Implementation Contact(s): Appropriate regional office</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.</p>
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***Unless otherwise specified, the effective date is the date of service.**

60.1 - Payment

(Rev. 1062, Issued: 09-22-06, Effective: 01-01-07, Implementation: 01-02-07)

Payment (carrier and FI) is under the MPFS except as follows:

- Fecal occult blood tests (*82270** (*G0107**) and G0328) are paid under the clinical diagnostic lab fee schedule except reasonable cost is paid to CAHs when submitted on TOB 85X. Deductible and coinsurance do not apply for these tests. See section A below for payment to Maryland waiver on TOB 13X. Payment from all hospitals for non-patient laboratory specimens on TOB 14X will be based on the clinical diagnostic fee schedule, including CAHs and Maryland waiver hospitals.
- Flexible sigmoidoscopy (code G0104) is paid under OPSS for hospital outpatient departments and on a reasonable cost basis for CAHs; or current payment methodologies for hospitals not subject to OPSS.
- Colonoscopy (G0105 and G0121) and barium enemas (G0106 and G0120) are paid under OPSS for hospital outpatient departments and on a reasonable costs basis for CAHs or current payment methodologies for hospitals not subject to OPSS. Also colonoscopies may be done in an Ambulatory Surgical Center (ASC) and when done in an ASC the ASC rate applies. The ASC rate is the same for diagnostic and screening colonoscopies.

The following screening codes must be paid at rates consistent with the diagnostic codes indicated.

Screening Code	Diagnostic Code
G0104	45330
G0105 and G0121	45378
G0106	74280
G0120	74280

Prior to January 1, 2007, deductible and coinsurance apply to the codes listed in the chart above. Beginning with services provided on or after January 1, 2007, Section 5113 of the Deficit Reduction Act of 2005 waives the requirement of the annual Part B deductible for these services. Coinsurance still applies.

A. Special Payment Instructions for TOB 13X Maryland Waiver Hospitals

For hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission, screening colorectal services HCPCS codes G0104, G0105, G0106, *82270** (*G0107**), G0120, G0121 and G0328 are paid according to the terms of the waiver, that is 94% of submitted charges minus any unmet existing deductible, co-insurance and non-

covered charges. Maryland Hospitals bill TOB 13X for outpatient colorectal cancer screenings.

B. Special Payment Instructions for Non-Patient Laboratory Specimen (TOB 14X) for all hospitals

Payment for colorectal cancer screenings (82270* (G0107*) and G0328) to a hospital for a non-patient laboratory specimen (TOB 14X), is the lesser of the actual charge, the fee schedule amount, or the National Limitation Amount (NLA), (including CAHs and Maryland Waiver hospitals). Part B deductible and coinsurance do not apply.

**NOTE: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with CPT code 82270.*

60.2 - HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable)

(Rev. 1062, Issued: 09-22-06, Effective: 01-01-07, Implementation: 01-02-07)

Effective for services furnished on or after January 1, 1998, the following codes are used for colorectal cancer screening services:

- 82270* (G0107*) - Colorectal cancer screening; fecal-occult blood tests, 1-3 simultaneous determinations;
- G0104 - Colorectal cancer screening; flexible sigmoidoscopy;
- G0105 - Colorectal cancer screening; colonoscopy on individual at high risk;
- G0106 - Colorectal cancer screening; barium enema; as an alternative to G0104, screening sigmoidoscopy;
- G0120 - Colorectal cancer screening; barium enema; as an alternative to G0105, screening colonoscopy.

Effective for services furnished on or after July 1, 2001, the following codes are used for colorectal cancer screening services:

- G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk. Note that the description for this code has been revised to remove the term “noncovered.”
- G0122 - Colorectal cancer screening; barium enema (noncovered).

Effective for services furnished on or after January 1, 2004, the following code is used for colorectal cancer screening services as an alternative to 82270* (G0107*):

- G0328 - Colorectal cancer screening; immunoassay, fecal-occult blood test, 1-3 simultaneous determinations

**NOTE: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with CPT code 82270.*

G0104 - Colorectal Cancer Screening; Flexible Sigmoidoscopy

Screening flexible sigmoidoscopies (code G0104) may be paid for beneficiaries who have attained age 50, when performed by a doctor of medicine or osteopathy at the frequencies noted below.

For claims with dates of service on or after January 1, 2002, contractors pay for screening flexible sigmoidoscopies (code G0104) for beneficiaries who have attained age 50 when these services were performed by a doctor of medicine or osteopathy, or by a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in §1861(aa)(5) of the Act and in the Code of Federal Regulations at 42 CFR 410.74, 410.75, and 410.76) at the frequencies noted above. For claims with dates of service prior to January 1, 2002, contractors pay for these services under the conditions noted only when a doctor of medicine or osteopathy performs them.

For services furnished from January 1, 1998, through June 30, 2001, inclusive:

- Once every 48 months (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was done).

For services furnished on or after July 1, 2001:

- Once every 48 months as calculated above **unless** the beneficiary does not meet the criteria for high risk of developing colorectal cancer (refer to §60.3 of this chapter) **and** he/she has had a screening colonoscopy (code G0121) within the preceding 10 years. If such a beneficiary has had a screening colonoscopy within the preceding 10 years, then he or she can have covered a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that he/she received the screening colonoscopy (code G0121).

NOTE: If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which 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 and paid rather than code G0104.

G0105 - Colorectal Cancer Screening; Colonoscopy on Individual at High Risk

Screening colonoscopies (code G0105) may be paid when performed by a doctor of medicine or osteopathy at a frequency of once every 24 months 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 G0105 screening colonoscopy was performed). Refer to §60.3 of this chapter for the criteria to use in determining whether or not an individual is at high risk for developing colorectal cancer.

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

A. Colonoscopy Cannot be Completed Because of Extenuating Circumstances

1. FIs

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. However, the frequency standards associated with screening colonoscopies will not be applied by CWF. 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, and the frequency standards will be applied by CWF. This policy is applied to both screening and diagnostic colonoscopies. When submitting a facility claim for the interrupted colonoscopy, providers are to suffix the colonoscopy HCPCS codes with a modifier of “-73” or “-74” as appropriate to indicate that the procedure was interrupted. Payment for covered incomplete screening colonoscopies shall be consistent with payment methodologies currently in place for complete screening colonoscopies, including those contained in 42 CFR 419.44(b). In situations where a critical access hospital (CAH) has elected payment Method II for CAH patients, payment shall be consistent with payment methodologies currently in place as outlined in Chapter 3. As such, instruct CAHs that elect Method II payment to use modifier “-53” to identify an incomplete screening colonoscopy (physician professional service(s) billed in 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 the “-73” or “-74” modifier as appropriate.

Note that Medicare would expect the provider to maintain adequate information in the patient’s medical record in case it is needed by the contractor to document the incomplete procedure.

2. Carriers

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances (see Chapter 12), Medicare will pay 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 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. When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with a modifier of “-53” to indicate that the procedure was interrupted. When submitting a claim for the facility fee associated with this procedure, Ambulatory Surgical Centers (ASCs) are to suffix the colonoscopy code with “-73” or “-74” as appropriate. Payment for covered screening colonoscopies, including that for the associated ASC facility fee when applicable, shall be consistent with payment for diagnostic colonoscopies, whether the procedure is complete or incomplete.

Note that Medicare would expect the provider to maintain adequate information in the patient’s medical record in case it is needed by the contractor to document the incomplete procedure.

G0106 - Colorectal Cancer Screening; Barium Enema; as an Alternative to G0104, Screening Sigmoidoscopy

Screening barium enema examinations may be paid as an alternative to a screening sigmoidoscopy (code G0104). The same frequency parameters for screening sigmoidoscopies (see those codes above) apply.

In the case of an individual aged 50 or over, payment may be made for a screening barium enema examination (code G0106) performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed. For example, the beneficiary received a screening barium enema examination as an alternative to a screening flexible sigmoidoscopy in January 1999. Start counts beginning February 1999. The beneficiary is eligible for another screening barium enema in January 2003.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening flexible sigmoidoscopy 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 above for the screening double contrast barium enema examination.

82270* (G0107*) - Colorectal Cancer Screening; Fecal-Occult Blood Test, 1-3 Simultaneous Determinations

Effective for services furnished on or after January 1, 1998, screening FOBT (code 82270* (G0107*)) may be paid for beneficiaries who have attained age 50, and at a

frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed). This screening FOBT means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. This screening requires a written order from the beneficiary's attending physician. (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) 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.)

Effective for services furnished on or after January 1, 2004, payment may be made for a immunoassay-based FOBT (G0328, described below) as an alternative to the guaiac-based FOBT, 82270* (G0107*). Medicare will pay for only one covered FOBT per year, either 82270* (G0107*) or G0328, but not both.

**NOTE: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with CPT code 82270.*

G0328 - Colorectal Cancer Screening; Immunoassay, Fecal-Occult Blood Test, 1-3 Simultaneous Determinations

Effective for services furnished on or after January 1, 2004, screening FOBT, (code G0328) may be paid as an alternative to 82270* (G0107*) for beneficiaries who have attained age 50. Medicare will pay for a covered FOBT (either 82270* (G0107*) or G0328, but not both) at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed). Screening FOBT, immunoassay, includes the use of a spatula to collect the appropriate number of samples or the use of a special brush for the collection of samples, as determined by the individual manufacturer's instructions. This screening requires a written order from the beneficiary's attending physician. (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) 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.)

G0120 - Colorectal Cancer Screening; Barium Enema; as an Alternative to or G0105, Screening Colonoscopy

Screening barium enema examinations may be paid as an alternative to a screening colonoscopy (code G0105) examination. The same frequency parameters for screening colonoscopies (see those codes above) apply.

In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination (code G0120) performed after at least 23 months have passed following the month in which the last screening barium enema or

the last screening colonoscopy was performed. For example, a beneficiary at high risk for developing colorectal cancer received a screening barium enema examination (code G0120) as an alternative to a screening colonoscopy (code G0105) in January 2000. Start counts beginning February 2000. The beneficiary is eligible for another screening barium enema examination (code G0120) in January 2002.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening colonoscopy, 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 above for the screening double contrast barium enema examination.

G0121 - Colorectal Screening; Colonoscopy on Individual Not Meeting Criteria for High Risk - Applicable On and After July 1, 2001

Effective for services furnished on or after July 1, 2001, screening colonoscopies (code G0121) performed on individuals not meeting the criteria for being at high risk for developing colorectal cancer (refer to §60.3 of this chapter) may be paid 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 G0121 screening colonoscopy was performed.)
- If the individual would otherwise qualify to have covered a G0121 screening colonoscopy based on the above **but** has had a covered screening flexible sigmoidoscopy (code G0104), then he or she may have covered a G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered G0104 flexible sigmoidoscopy was performed.

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

G0122 - Colorectal Cancer Screening; Barium Enema

The code is not covered by Medicare.

60.2.1 - Common Working Files (CWF) Edits

(Rev. 1062, Issued: 09-22-06, Effective: 01-01-07, Implementation: 01-02-07)

Effective for dates of service January 1, 1998, and later, CWF will edit all *colorectal screening* claims for age and frequency standards. The CWF will also edit FI claims for valid procedure codes (G0104, G0105, G0106, *82270* (G0107*)*, G0120, G0121, G0122, and G0328) *and* for valid bill types. The CWF currently edits for valid HCPCS codes for carriers. (See §60.6 of this chapter for bill types.)

**NOTE: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with CPT code 82270.*

60.6 - Billing Requirements for Claims Submitted to FIs

(Rev. 1062, Issued: 09-22-06, Effective: 01-01-07, Implementation: 01-02-07)

Follow the general bill review instructions in Chapter 25. Hospitals use the ANSI X12N 837I to bill the FI or on the hardcopy Form CMS-1450. Hospitals bill revenue codes and HCPCS codes as follows:

Screening Test/Procedure	Revenue Code	HCPCS Code	TOB
Fecal Occult blood test	030X	<i>82270*** (G0107***),</i> G0328	13X, 14X**, <i>22X, 23X,</i> 83X, 85X
Barium enema	032X	G0106, G0120, G0122	13X, <i>22X,</i> <i>23X,</i> 85X****
Flexible Sigmoidoscopy	*	G0104	13X, <i>22X,</i> <i>23X,</i> 83X, 85X****
Colonoscopy-high risk	*	G0105, G0121	13X, <i>22X,</i> <i>23X,</i> 83X, 85X****

* The appropriate revenue code when reporting any other surgical procedure.

** 14X is only applicable for non-patient laboratory specimens.

**** For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107, is discontinued and replaced with CPT code 82270.*

***** CAHs that elect Method II bill revenue code 096X, 097X, and/or 098X for professional services and 075X (or other appropriate revenue code) for the technical or facility component.*

A Special Billing Instructions for Hospital Inpatients

When these tests/procedures are provided to inpatients of a hospital, they are covered under this benefit. However, the provider bills on bill type 13X using the discharge date of the hospital stay to avoid editing in the Common Working File (CWF) as a result of the hospital bundling rules.

60.7 - MSN Messages

(Rev. 1062, Issued: 09-22-06, Effective: 01-01-07, Implementation: 01-02-07)

The following MSN messages are used (See Chapter 21 for the Spanish versions of these messages):

A. If a claim for a screening fecal-occult blood test, a screening flexible sigmoidoscopy, or a barium enema is being denied because of the age of the beneficiary, MSN message 18.13 is used.

This service is not covered for patients under 50 years of age.

B. If the claim for a screening fecal-occult blood test, a screening colonoscopy, a screening flexible sigmoidoscopy, or a barium enema is being denied because the time period between the same test or procedure has not passed, MSN message 18.14 is used:

Service is being denied because it has not been (12, 24, 48, 120) months since your last (test/procedure) of this kind.

C. If the claim is being denied for a screening colonoscopy or a barium enema because the beneficiary is not at a high risk, MSN message 18.15 is used:

Medicare covers this procedure only for patients considered to be at a high risk for colorectal cancer.

D. If the claim is being denied because payment has already been made for a screening fecal-occult blood test (*82270* (G0107*)* or G0328), flexible sigmoidoscopy (code G0104), screening colonoscopy (code G0105), or a screening barium enema (codes G0106 or G0120), MSN message 18.16 is used:

This service is denied because payment has already been made for a similar procedure within a set timeframe.

NOTE: MSN message 18-16 should only be used when a certain screening procedure is performed as an alternative to another screening procedure. For example: If the claims

history indicates a payment has been made for code G0120 and an incoming claim is submitted for code G0105 within 24 months, the incoming claim should be denied.

E. If the claim is being denied for a noncovered screening procedure code such as G0122, the following MSN message 16.10 is used:

Medicare does not pay for this item or service.

If an invalid procedure code is reported, the contractor will return the claim as unprocessable to the provider under current procedures.

**NOTE: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with CPT code 82270.*