Medicare Preventive Services:

Women's Health

A Guide to Billing Mammograms, PAP Tests, Pelvic Exams and Colon Cancer Screenings

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Learning Network

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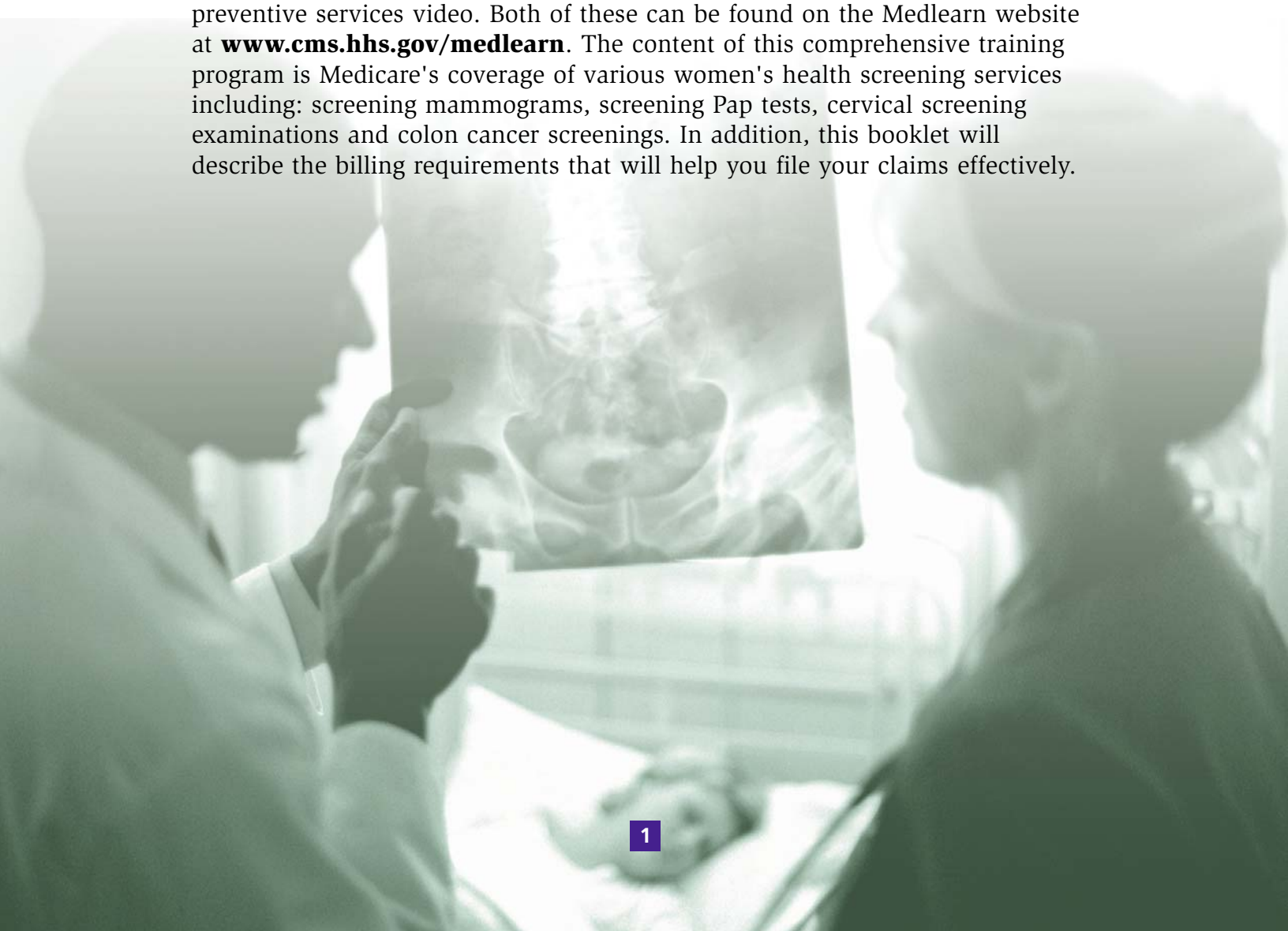
INTRODUCTION

A Guide to Billing Mammograms, PAP Tests, Pelvic Exams and Colon Cancer Screenings

Every year the statistics are getting better. Focusing on the early detection and prevention of cancer has worked! The national mortality rates for most types of cancer have decreased tremendously, and certain cancers can be cured, if detected early.

The Centers for Medicare & Medicaid Services (CMS) has developed a comprehensive training program to promote awareness and increase utilization of Medicare preventive benefits. The program also describes billing requirements and helps health care providers build their practices by promoting wellness. Complimentary training includes a web based training and a preventive services video. Both of these can be found on the Medlearn website at **www.cms.hhs.gov/medlearn**. The content of this comprehensive training program is Medicare's coverage of various women's health screening services including: screening mammograms, screening Pap tests, cervical screening examinations and colon cancer screenings. In addition, this booklet will describe the billing requirements that will help you file your claims effectively.



SCREENING MAMMOGRAMS

Background

Medicare's coverage of screening mammograms was created as a result of the implementation of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). This act authorized Medicare to begin covering screening mammograms on or after January 1, 1991. The statutory frequency parameters and age limits were more stringent than they are today. OBRA 1990 allowed Medicare to cover screening mammograms once every two years for those beneficiaries who were classified as "low risk" and once a year for those beneficiaries who were classified as "high risk". The Balanced Budget Act (BBA) of 1997 revised the statutory frequency parameters and age limitations Medicare uses to cover screening mammograms. The Benefits Improvement and Protection Act (BIPA) 2000, established coverage and payment of computer-aided detection (CAD) in conjunction with the performance of a mammogram.

The term **"screening mammography"** is defined as mammography performed on an asymptomatic female patient to detect the presence of breast cancer at an early stage. In screening mammography, the patient typically has not manifested any clinical signs, symptoms, or physical findings of breast cancer. The screening mammogram is performed to detect the presence of a breast abnormality in its incipient stage and to serve as a baseline to which future screening or diagnostic mammograms may be compared.

The term **"diagnostic mammography"** is defined as mammography performed on a male or female patient with clinical signs, symptoms, or physical findings suggestive of breast cancer, an abnormal or questionable screening mammogram; a personal history of breast cancer; or a personal history of biopsy-proven benign breast disease. Diagnostic mammography is also called problem-solving mammography or consultative mammography. A diagnostic mammogram is performed because there is a reasonable suspicion that an abnormality may exist in the breast. The diagnostic mammogram may confirm or deny the presence of an abnormality, and if confirmed, may assist in determining the nature of the problem.

The following information outlines Medicare's coverage of screening mammograms, including important billing information that will help you when you file your claims.

Certification and Coverage Requirements

Certification Requirements

Effective October 1, 1994, the Mammography Quality Standards Act (MQSA) requires that all facilities providing mammogram services (both screening and diagnostic using film screen and/or full shield digital mammography) meet national quality standards in order to operate. Facilities providing any mammogram service must be accredited by a designated accreditation body and certified by the Food and Drug Administration (FDA) or the State of Iowa or the State of Illinois Department of Radiation Protection (for facilities located in either the states of Iowa or Illinois).

To become a certified mammography facility, the FDA requires that the facility receive accreditation through one of the following accreditation bodies:

- The American College of Radiology (ACR)

If a facility is located in one of the following four states, the facility may apply for accreditation through either the ACR or the appropriate State Department of Radiation Protection in which it is located:

- Arkansas (SAR);
- Iowa (SIA);
- California (SCA); and
- Texas (STX).

Once the facility becomes accredited, it will receive a certificate from either the FDA or the states of Iowa or Illinois (if a facility is located within those states). After the certificate is processed the certification record will be forwarded to CMS, who will provide the FDA Facility Identification Number and other applicable information to the carrier.

Medicare carriers are required to notify providers at least once a year, through their provider/supplier publications regarding the certified mammography facilities in the carrier's jurisdiction. If you are ordering a mammogram for your patients, please refer them to a certified mammography facility. You should contact your local carrier for a list of certified facilities in your area as well as, **www.fda.gov/cdrh/mammography/certified.html,** the FDA's web site.

Medicare will deny payment of the mammogram if:

- A facility is NOT certified or
- A facility, whose certificate is suspended or revoked, renders the service

Coverage Requirements

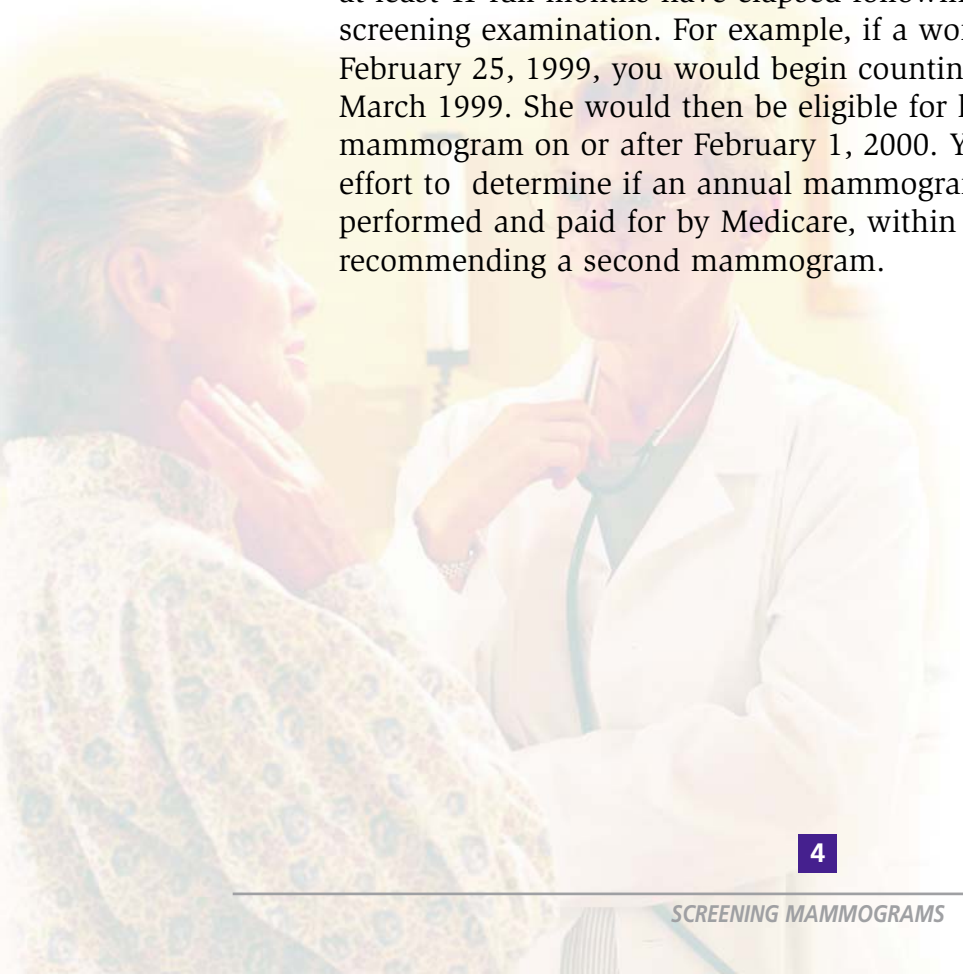
A physician's prescription or referral is not required for coverage of a screening mammogram, but State law may be more restrictive. Medicare's coverage guidelines for screening mammograms were revised as a result of legislation included in the Balanced Budget Act (BBA) of 1997. These changes became effective for services rendered on and after January 1, 1998. The changes are as follows:

- screening mammograms are covered annually for women over age 39
- the Medicare Part B deductible is waived

AGE STATUS	SCREENING PERIOD
35-39	Baseline (only one allowed for this age group)
40 and over	Annual

NOTE:

- For women between the ages of 35-39 you should make every effort to determine if a baseline mammogram has already been performed and paid for by Medicare, within the last several years, prior to recommending a second mammogram.
- For women who are age 40 or older, "annual" frequency means that at least 11 full months have elapsed following the month of the last screening examination. For example, if a woman had an exam on February 25, 1999, you would begin counting with the month of March 1999. She would then be eligible for her next screening mammogram on or after February 1, 2000. You should make every effort to determine if an annual mammogram has already been performed and paid for by Medicare, within the past year, prior to recommending a second mammogram.



Billing/Coding Requirements

Procedure Code and Descriptor

- **76092 Screening mammography, bilateral**
- **G0202 Screening mammography, producing direct digital image, all views**

Diagnosis and Other Claim Filing Requirements

If your patient is considered "high-risk", diagnosis code V76.11 (screening mammogram for high-risk patient) should be reported when filing your claim.

A patient is considered **high-risk** for breast cancer if one or more of the following conditions apply:

- V10.3 Personal history-Malignant neoplasm female breast
- V16.3 Family history-Malignant neoplasm breast
- V15.89 Other specified personal history representing hazards to health.

If your patient is determined to be **high-risk**, you should also report one of the above diagnoses **in addition to** the routine screening diagnosis (V76.11) when filing your Medicare claim. In this situation, you should report both diagnosis code V76.11 **and** the applicable high-risk diagnosis code(s) in block 21 of the CMS-1500 claim form or the applicable electronically formatted field. In block 24e of the CMS claim form or the applicable electronically formatted field, you should report diagnosis code V76.11. Failure to report the V76.11 diagnosis code in block 24e of the CMS-1500 claim form or the applicable electronically formatted field will result in denial of your claim.

If the patient is not at "high-risk", diagnosis code V76.12 (other screening mammography) should be utilized. In this situation, you should report diagnosis code V76.12 in both blocks 21 and 24e of the CMS-1500 claim form, or the applicable electronically formatted fields. Failure to report the V76.12 diagnosis code in block 24e of the CMS-1500 claim form, or the applicable electronically formatted field will result in denial of your claim.

You must enter the six-digit FDA Facility Identification number in either block 32 of the CMS-1500 claim form or in the applicable electronically formatted field. If you do not provide the facility certification number on the claim form, the service will deny as "unprocessable", and appeal rights do not apply. Services denied as "unprocessable" should be resubmitted to the carrier with the correct information. If you need the six digit FDA Facility Identification Number for the mammography facility, please refer to your carrier publications or to your local carrier.

Any service that is referred or ordered by a physician requires the referring/ordering physician's name and UPIN to be reported in blocks 17 and 17a on the CMS-1500 claim form, or the applicable electronically formatted fields.

Radiologists who order additional films based on the findings of the screening mammogram should enter the treating/referring physician's name and UPIN on the claim.

Need for Additional Films

For dates of service on or after January 1, 2002-New billing instructions apply. Medicare allows additional films to be done without an additional order from the treating physician. When submitting a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach Modifier GG to the diagnostic mammography. We are requiring Modifier GG be appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Both the screening mammography and the diagnostic mammography will be reimbursed by Medicare.

- **76090 Diagnostic mammogram; unilateral**
- **76091 Diagnostic mammogram; bilateral**
- **G0204 Diagnostic mammogram, producing direct digital image, bilateral, all views**
- **G0206 Diagnostic mammogram, producing direct digital image, unilateral, all views**

Coding Tip

- Even though Medicare does not require a physician's order or referral for payment of a screening mammogram, physicians who routinely write orders or referrals for mammograms should clearly indicate the type of mammogram (screening or diagnostic) the patient is to receive. Also the order should include the applicable ICD-9 diagnosis code that reflects the reason for the test and the date of the last screening mammogram. This information will be reviewed by the radiologist who can ensure that the beneficiary receives the correct (screening or diagnostic) service.

In 2000, computer-aided detection (CAD) payment was built into the payment of the digital mammography services. Effective January 1, 2001, CAD was billable as a separately identifiable add-on code that must be performed in conjunction with a base mammography code. CAD can be billed in conjunction with both standard film and direct digital image screening and diagnostic mammography services.

Reimbursement Policy

The Medicare Part B deductible is waived for screening mammograms. The 20 percent coinsurance is applicable.

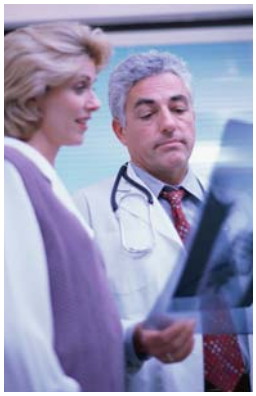
A provider may bill for a mammogram service in one of the following three ways: (1) for the professional component only; (2) for the technical component only; or (3) for the global/complete service.

Written Advance Notification Requirements

Advance notice is applicable for beneficiaries who do not meet age requirements or exceed statutory frequency parameters. Since statutory frequency parameters are printed in the Medicare Handbook, and liability statements are printed on all Medicare Summary Notices, sent to beneficiaries receiving a screening mammogram, Medicare does not require the physician to have the beneficiary sign an advanced notification form.

Intermediary Billing Requirements

Global billing (both professional and technical components) is not permitted for services furnished in an outpatient setting. If services are rendered in an outpatient facility setting, the provider should bill the intermediary for the technical component using the CMS-1450 (or UB92) claim form. The professional component should be billed to the carrier using the CMS-1500 claim form.



When billing the technical component using the 1450 claim form, the bill type should be 14X, 71X (provider ranges 3400-3499, 3975-3999 and 8500-8899) or 85X. Each intermediary may choose to accept other bill types for the technical component of the screening mammogram. If you would like to bill using a bill type other than 14X, 71X or 85X, please contact your local intermediary to determine if the particular bill type is allowed. The appropriate revenue code is 403, which should be used in conjunction with procedure code 76092 and G0202. The age of the beneficiary, the date of the last screening mammogram and the presence of a high-risk diagnosis indicator should also be included in the applicable fields. When submitting this service to the intermediary, do not include any other service(s) on the claim.

For dates of service on or after January 1, 2002—new billing instructions apply. Medicare allows additional films to be done without an additional order from the

treating physician. Instruct providers that when submitting a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach a Modifier GG to the diagnostic mammography (CPT codes 76090 and 76091 or HCPCS codes G0204 or G0206). Medicare requires Modifier GG be appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Both the screening mammography and the diagnostic mammography will be reimbursed by Medicare.

NOTE: Rural health clinics (RHCs) should abide by these same guidelines.

SCREENING PAP TESTS

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The Pap test (Papanicolaou Smear/Test) is a cytologic examination of a vaginal smear for early detection of cancer (especially of the cervix and uterus), employing exfoliated cells and a special staining technique that differentiates diseased tissue.

Medicare's coverage of the screening Pap test was created as a result of the implementation of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989). This Act authorized Medicare to begin covering screening Pap tests provided to female beneficiaries on or after July 1, 1990. The OBRA of 1989 allowed Medicare to cover screening Pap tests once every three years for those beneficiaries who were classified as "low risk" and allowed for annual Pap tests for those beneficiaries who were classified as "high risk". The Benefits Improvement and Protection Act of 2000 amended the screening frequency from once every three years to once every two years for the "low risk" beneficiary.

The following information outlines Medicare's coverage of screening Pap tests, including important billing information that will help you when you file your claims.

Coverage Requirements

The Benefits Improvement and Protection Act of 2000 includes coverage **every two years** for a screening Pap test for "low risk" women and left unchanged the annual coverage for the screening test for women who exhibit any one of the following conditions:

- women who are either at high-risk of developing cervical or vaginal cancer
- women who are of childbearing age who have had a Pap test during any of the preceding three years indicating the presence of cervical or vaginal cancer.

Medicare covers screening Pap tests when they are ordered and collected by a doctor of medicine or osteopathy, or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under state law to perform the examination) under one of the following conditions:

- The patient has not had a screening Pap test during the preceding 2 years and is at low risk for developing cervical or vaginal cancer use one of the following ICD-9-CM codes V76.2, V76.47 or V76.49
- There is evidence (on the basis of the patient's medical history or other findings) that the patient is of childbearing age and has had an examination indicating the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years; or that she is at high-risk of developing cervical or vaginal cancer (use ICD-9-CM code V15.89, other specified personal history presenting hazards to health).

Cervical and Vaginal Cancer High-Risk Factors

The high-risk factors for cervical and vaginal cancer include any of the following:

- early onset of sexual activity (under 16 years of age) (use ICD-9-CM code V69.2 High-risk Sexual Behavior *as a secondary* diagnosis to V15.89)
- multiple sexual partners (five or more in a lifetime)
- history of a sexually transmitted disease (including HIV infection)
- fewer than three negative Pap tests within the previous seven years
- DES (diethylstilbestrol).

The term "women of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings. Payment is not made for a screening Pap test for women at high-risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after the month that the last screening Pap test covered by Medicare was performed.

Billing/Coding Requirements

Procedure Codes and Descriptors

There are six HCPCS codes for reporting screening Pap tests. Code selection depends on the reason for performing the test, the methods of specimen preparation and evaluation, and the reporting system used. The HCPCS codes used to report screening Pap tests are listed below.

- **G0123 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision**
- **G0143 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision**
- **G0144 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system under physician supervision**
- **G0145 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system under physician supervision**
- **G0147 Screening cytopathology smears, cervical or vaginal; performed by automated system under physician supervision**
- **G0148 Screening cytopathology smears, cervical or vaginal; performed by automated system with manual reevaluation**

There are three HCPCS codes for reporting the physician's interpretation of screening Pap tests. Code selection depends on the reason for performing the test, the methods of specimen preparation and evaluation, and the reporting system used.

The following HCPCS codes are used to report the physician's interpretation of screening Pap tests:

- **G0124 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician**
- **G0141 Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening, requiring interpretation by physician**
- **P3001 Screening Papanicoloau smear, cervical or vaginal, up to three smears, requiring interpretation by physician**

The following code should be used when the physician obtains, prepares, conveys the test and sends the specimen to a laboratory:

- **Q0091 Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory**

Diagnosis Criteria

When filing your claim for a screening Pap test, you must report either ICD-9-CM diagnosis code V76.2, V76.47, V76.49 or V15.89 (depending on whether your patient was classified as low or high risk) in block 24e of the CMS-1500 claim form or the applicable electronically formatted field. This diagnosis code, along with other applicable diagnosis codes, should also be reported in block 21 of the CMS-1500 claim form or the applicable electronically formatted fields. Failure to report the V76.2, V76.47, V76.49 or V15.89 diagnosis code in block 24e of the CMS-1500 claim form, or the applicable electronically formatted field will result in denial of your claim.

Reimbursement Policy

The Medicare Part B deductible for screening Pap test services paid for under the physician fee schedule is waived due to provisions of the Balanced Budget Act of 1997.

Intermediary Billing Requirements

Facilities should use bill type 13X, 14X, 22X, 23X, 71X, 73X or 85X. Each intermediary may choose to accept other bill types for the technical component of the Pap test. If you would like to bill using a bill type other than 13X, 14X, 22X, 23X, 24X or 71X, 73X or 85X, please contact your local intermediary to determine if the particular bill type is allowed. The revenue code submitted should be 311 (Cytology). When using bill type 13X, 14X, 22X, 23X, 71X, 73X or 85X the appropriate screening Pap test HCPCS code should also be submitted.

SCREENING PELVIC EXAMINATION

Medicare's coverage of the screening pelvic examination was created as a result of the implementation of the Balanced Budget Act of 1997. The Balanced Budget Act includes coverage of a screening pelvic examination for all female beneficiaries, effective January 1, 1998.

Coverage Requirements

Medicare covers cervical/breast exams when they are performed by a doctor of medicine or osteopathy, or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist), who is authorized under state law to perform the examination. This examination does not have to be ordered by a physician or other authorized practitioner.

A screening pelvic examination (including a clinical breast examination) should include *at least seven* of the following elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;
- Pelvic examination (with or without specimen collection for smears and cultures) including:
  - External genitalia (e.g., general appearance, hair distribution or lesions)
  - Urethral meatus (e.g., size, location, lesions or prolapse)
  - Urethra (e.g., masses, tenderness or scarring)
  - Bladder (e.g., fullness, masses or tenderness)
  - Vagina (e.g., general appearance, estrogen effect, discharge lesions, pelvic support, cystocele or rectocele)
  - Cervix (e.g., general appearance, discharge or lesions)
  - Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
  - Adnexa/parametria (e.g., masses, tenderness, organomegaly or nodularity)
  - Anus and perineum.

Payment may be made for a screening pelvic examination performed on an asymptomatic woman only if the individual has not had a screening pelvic exam paid for by Medicare during the preceding 23 months following the month in which the last Medicare covered screening was performed. Use one of the following ICD-9-CM codes: V76.2, V76.47, V76.49 There are two exceptions:

- There is evidence that the woman is at high-risk (on the basis of her medical history or other findings) of developing cervical cancer or vaginal cancer (Use ICD-9-CM diagnosis code V15.89, other specified personal history presenting hazards to health); or
- A woman of childbearing age has had such an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding three years.

NOTE: The high-risk factors for cervical and vaginal cancer are the same as for Pap tests.

Billing/Coding Requirements

Procedure Code and Descriptor

- **G0101 Cervical or vaginal cancer screening; pelvic and clinical breast examination**

Diagnosis Criteria

When filing your claim for a screening Pap test, you must report either ICD-9-CM diagnosis code V76.2, V76.47, V76.49 or V15.89 (depending on whether your patient was classified as low or high risk) in block 24e of the CMS-1500 claim form or the applicable electronically formatted field. This diagnosis code, along with other applicable diagnosis codes, should also be reported in block 21 of the CMS-1500 claim form or the applicable electronically formatted fields. Failure to report the V76.2, V76.47, V76.49 or V15.89 diagnosis code in block 24e of the CMS-1500 claim form, or the applicable electronically formatted field will result in denial of your claim.

Coding Tips

- A screening Pap smear and a screening pelvic examination can be performed during the same encounter. When this happens, both procedure codes should be shown as separate line items on the claim.
- A covered evaluation and management visit and code G0101 may be reported by the same physician for the same date of service if the evaluation and management visit is for separately identifiable service. In this case, the modifier "-25" must be reported with the evaluation and management service and the medical records must clearly document the evaluation and management service reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately on separate office visits. For more detailed information regarding coverage of screening pelvic examinations, please refer to Transmittal 1823.

Reimbursement Policy

Pelvic examinations are paid under the physician fee schedule and the deductible is waived. Coinsurance still applies.

Intermediary Billing Requirements

Facilities should use bill type 12X, 13X, 14X, 22X, 23X, 71X, 73X or 85X. Each intermediary may choose to accept other bill types for the pelvic exam. If you would like to bill using a bill type other than 12X, 13X, 14X, 22X, 23X, 71X, 73X or 85X, please contact your local intermediary to determine if the particular bill type is allowed. The revenue code submitted should be 770A (Preventive Care Services—General Classification).

COLON CANCER SCREENINGS

Medicare Learning Network

Medicare's coverage of various colon cancer screening procedures was created as a result of the implementation of the Balanced Budget Act of 1997. The Balanced Budget Act provides coverage of various colon-screening examinations subject to certain coverage, frequency, and payment limitations. Effective for services furnished on and after January 1, 1998, Medicare will cover colon cancer screening tests/procedures for the early detection of colon cancer. Effective July 1, 2001 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.

Coverage of colon cancer screening tests includes the following procedures furnished to an individual for the early detection of colon cancer:

- Screening fecal-occult blood test
- Screening flexible sigmoidoscopy
- Screening colonoscopy
- Screening barium enema as an alternative to a screening flexible sigmoidoscopy or screening colonoscopy.

Coverage Requirements

The following are the coverage requirements for these new screenings:

Screening Fecal-Occult Blood Test

These tests are covered at a frequency of once every 12 months for beneficiaries who have attained age 50 (i.e., at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). Screening fecal-occult blood test 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.)

Screening Flexible Sigmoidoscopy

For services furnished on or after July 1, 2001

This procedure is covered at a frequency of once every 48 months unless the beneficiary does not meet the criteria for high risk of developing colorectal cancer and has had a screening colonoscopy within the preceding 10 years. If such beneficiary has had a screening colonoscopy within the preceding 10 years, then the beneficiary can have covered a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that the screening colonoscopy was performed.

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. A doctor of medicine or osteopathy must perform this screening.

Screening Colonoscopy

For Beneficiaries at High Risk of Developing Colorectal Cancer

This procedure is covered at a frequency of once every 24 months for beneficiaries at high-risk for colon cancer (i.e., at least 23 months have passed following the month in which the last covered screening colonoscopy was done).

For Beneficiaries Not at High Risk of Developing Colorectal Cancer

Effective for services furnished on or after July 1, 2001, this procedure is covered at a frequency of once every 10 years but not within 48 months of a screening flexible sigmoidoscopy (i.e., at least 119 months have passed following the

month in which the last screening colonoscopy was done and at least 47 months have passed following the month in which the last screening flexible sigmoidoscopy was done).

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. A doctor of medicine or osteopathy must perform this screening.

Screening Barium Enema

These procedures are covered as an alternative to either a screening sigmoidoscopy or a screening colonoscopy.

In the case of an individual age 50 or over who is not at high-risk of colon cancer, payment may be made for a screening barium enema examination performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed.

In the case of an individual who is at high-risk for colon cancer, payment may be made for a screening barium enema examination 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.

The screening barium enema (preferably a double contrast barium enema) must be ordered in writing after a determination that the test is the appropriate screening test. If the individual cannot withstand a double contrast barium enema, the attending physician may order a single contrast barium enema. 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, 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 above for the screening double contrast barium enema examination.

Characteristics of the High Risk Individual

High-risk for colon cancer means an individual with one or more of the following:

- A close relative (sibling, parent, or child) who has had colon cancer or an adenomatous polyposis
- A family history of familial adenomatous polyposis
- A family history of hereditary nonpolyposis colon cancer
- A personal history of adenomatous polyps
- A personal history of colon cancer
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis

Determining Statutory Frequency Parameters

To determine the 11, 23, 47, and 119-month periods, start your count beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received a fecal-occult blood test in January 1998. Start your count beginning with February 1998. The beneficiary is eligible to receive another blood test in January 1999 (the month after 11 full months have passed).

Billing/Coding Requirements

Procedure Codes and Descriptors

The following codes have been established for these services:

- **G0107 Colon cancer screening; fecal-occult blood test, 1-3 simultaneous determinations**
- **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, screening sigmoidoscopy**
- **G0120 Colon cancer screening; barium enema; as an alternative to G0105, screening colonoscopy**
- **G0121 Colon cancer screening; colonoscopy on individuals not meeting criteria for high-risk, and**
- **G0122 Colon cancer screening; barium enema (non-covered).**

NOTE: It is improper to bill procedure code **G0107 (Colon cancer screening; fecal occult blood test, 1-3 simultaneous determinations)** on three different line items or for three consecutive days. This procedure code should only be reported **once**.

The reimbursement for this code takes into consideration the fact that the test was done on three different days. You should report the date the test was actually performed on your patient's sample, not the date you issued the test to the patient or when the patient returned the test to your office.

Non-Covered Colon Cancer Screening Services

Code **G0122** (**colon cancer screening; barium enema**) should be used when a screening barium enema is performed NOT as an alternative to either a screening colonoscopy (code **G0105**) or a screening flexible sigmoidoscopy (code **G0104**). 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 these non-covered codes will also allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes.

Diagnosis Criteria

For the screening colonoscopy, the beneficiary does not have to present with any signs/symptoms. However, when billing for the "high-risk" patient, the appropriate high-risk ICD-9 diagnosis code should be submitted. Listed below are some examples of diagnoses that meet high-risk criteria for colon cancer. This is not an all-inclusive list. There may be more instances of conditions that could be coded and would be applicable to this legislation.

ICD-9-CM Codes

Personal History

- V10.05 Personal history of malignant neoplasm of large intestine
- V10.06 Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

Chronic Digestive Disease Condition

- 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 (non-specific PDX on the MCE)

Inflammatory Bowel

- 558.2 Toxic gastroenteritis and colitis
- 558.9 Other and unspecified non-infectious gastroenteritis and colitis

Reimbursement Policy

For the colon screening procedures, Medicare pays 80 percent of the approved amount or the submitted charge, whichever is lower. Deductible and co-insurance do apply.

Intermediary Billing Requirements

Facilities should use bill type 13X, 83X or 85X. In addition, the following revenue and HCPCS codes should be billed:

Screening Test/Procedure	Revenue Code	HCPCS Code
Occult blood test	30X	G0107
Barium enema	32X	G0106, G0120, G0122
Flexible sigmoidoscopy		*G0104
Colonoscopy		*G0105, G0121

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

Each intermediary may choose to accept other bill types for the colon cancer screening procedures. If you would like to bill using a bill type other than 13X, 83X or 85X, please contact your local intermediary to determine if the particular bill type is allowed.