Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1536

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2001*
IMPLEMENTATION DATE: July 1, 2001

Effective July 1, 2001, recent legislation expands the colorectal screening benefit to include colonoscopies for Medicare beneficiaries not at high risk for developing colorectal cancer. All of §4180 has been revised to reflect the new benefit and its impact on existing screening benefits.

Section 4180.1, Covered Services and HCPCS Codes, is a new section which consolidates descriptions of covered procedures and lists the appropriate codes.

Section 4180.2, Coverage Criteria, describes these criteria for each of the codes for covered services.

Section 4180.3, Determining Whether or Not the Beneficiary is at High Risk for Developing Colorectal Cancer, describes these criteria in a section central to §4180.

Section 4180.4, Determining Frequency Standards, explains how to calculate frequency standards based on the coverage requirements.

Section 4180.5, Noncovered Services, lists the codes that may be used for noncovered colorectal screening services for the purposes of providing a written denial for beneficiaries who need one for other insurance purposes.

Section 4180.6, Payment Requirements, describes the payment requirements for the covered codes.

Section 4180.7, Common Working File (CWF) Edits, explains the types of edits CWF will in general perform for these benefits.

Section 4180.8, Medicare Summary Notices (MSNs) and Explanations of Your Part B Medicare Benefits (EOMBs), describes the messages which must be used for denials of claims.

Section 4180.9, Remittance Advice Notices, describes the remittance advice messages which must be used for denials of claims.

Section 4180.10, Ambulatory Surgical Center Facility Fee, explains how to calculate payment for services performed in Ambulatory Surgical Centers (ASCs).

Inform providers of coding, payment, and claims submission requirements by posting that information on your web site as soon as possible and publishing it in your next regularly scheduled bulletin.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CHAPTER IV

Hospice Care

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CHAPTER IV

Section

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4180. COLORECTAL CANCER SCREENING

4180.1 Covered Services and HCPCS Codes.-- Medicare covers colorectal cancer screening test/procedures for the early detection of colorectal cancer for the HCPCS codes indicated.

A. Effective for Services Furnished on or After January 1, 1998.--

G0107--Colorectal cancer screening; fecal-occult blood test, 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

B. Effective for Services Furnished on or After July 1, 2001.--

G0121--Colorectal screening; colonoscopy on individual not meeting criteria for high risk

NOTE: The description of this code has been revised to remove the term "noncovered."

4180.2 Coverage Criteria.--The following are the coverage criteria for these screenings:

A. Screening Fecal-Occult Blood Tests (Code G0107).--Effective for services furnished on or after January 1, 1998, pay for screening fecal-occult blood tests (code G0107) 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 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 Social Security 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.)

B. Screening Flexible Sigmoidoscopies (code G0104).--Pay for screening flexible sigmoidoscopies (code G0104) for beneficiaries who have attained age 50 when performed by a doctor of medicine or osteopathy at the following frequencies:

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 §4180.3) **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.

C. Screening Colonoscopies For Beneficiaries At High Risk Of Developing Colorectal Cancer (Code G0105).--Pay for screening colonoscopies (code G0105) 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 §4180.3 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.

D. Screening Colonoscopies Performed on Individuals Not Meeting the Criteria for Being at High-Risk for Developing Colorectal Cancer (Code G0121).--Effective for services furnished on or after July 1, 2001, pay for screening colonoscopies (code G0121) performed under the following conditions:

1. On individuals not meeting the criteria for being at high risk for developing colorectal cancer (refer to §4180.3).

2. 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.)

3. If the individual would otherwise qualify to have covered a G0121 screening colonoscopy based on the above (see §4180.2.D.1 and .2) **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.

E. Screening Barium Enema Examinations (codes G0106 and G0120).--Screening barium enema examinations are covered as an alternative to either a screening sigmoidoscopy (code G0104) or a screening colonoscopy (code G0105) examination. The same frequency parameters for screening sigmoidoscopies and screening colonoscopies (see §4180.2 B and C) 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 1998. Start your count beginning February 1998. The beneficiary is eligible for another screening barium enema in January 2002.

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 1998. Start your count beginning February 1998. The beneficiary is eligible for another screening barium enema examination (code G0120) in January 2000.

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, 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.

4180.3 Determining Whether or Not the Beneficiary is at High Risk for Developing Colorectal Cancer.--

A. Characteristics of the High Risk Individual.--An individual at high risk for developing colorectal cancer has one or more of the following:

-- 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
-- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

B. Partial List of ICD-9-CM Codes Indicating High Risk.-- Listed below are some examples of diagnoses that meet the high risk criteria for colorectal cancer. This is not an all inclusive list. There may be more instances of conditions which may be coded and could be at the medical directors' discretion.

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

4180.4 Determining Frequency Standards.--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).

4180.5 Noncovered Services.--The following noncovered HCPCS codes are used to allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes for the dates of service indicated:

A. From January 1, 1998 Through June 30, 2001, Inclusive.--Code G0121 (colorectal cancer screening; colonoscopy on an individual not meeting criteria for high risk) should be used when this procedure is performed on a beneficiary who does NOT meet the criteria for high risk. This service should be denied as noncovered because it fails to meet the requirements of the benefit for these dates of service. The beneficiary is liable for payment. Note that this code is a covered service for dates of service on or after July 1, 2001.

B. On or After January 1, 1998.--Code G0122 (colorectal 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 should be denied as noncovered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

4180.6 Payment Requirements.--Code G0107 (colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations) must be paid at the rates established for this code under the clinical laboratory fee schedule.

Code G0104 (colorectal cancer screening; flexible sigmoidoscopy) must be paid at rates consistent with payment for similar or related services under the physician fee schedule, not to exceed the rates for a diagnostic flexible sigmoidoscopy (CPT code 45330). (The same RVUs have been assigned to code G0104 as those assigned to CPT code 45330.) 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 procedure classified as a flexible sigmoidoscopy with biopsy or removal must be billed and paid rather than code G0104.

Codes G0105 and G0121 (colorectal cancer screening colonoscopies) must be paid at rates consistent with payment for similar or related services under the physician fee schedule, not to exceed the rates for a diagnostic colonoscopy (CPT code 45378). (The same RVUs have been assigned to code G0105 and G0121 as those assigned to CPT code 45378.) 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 procedure classified as a colonoscopy with biopsy or removal must be billed and paid rather than code G0105 or G0121.

Code G0106 (colorectal cancer screening; barium enema as an alternative to a screening flexible sigmoidoscopy) must be paid at rates consistent with payment for similar or related services under the physician fee schedule, not to exceed the rates for a diagnostic barium enema (CPT code 74280).

Code G0120 (colorectal cancer screening; barium enema as an alternative to a screening colonoscopy; high risk individuals) must be paid at rates consistent with payment for similar or related services under the physician fee schedule, not to exceed the rates for a diagnostic barium enema (CPT code 74280).

4180.7 Common Working File (CWF) Edits.--Effective for dates of service January 1, 1998, and later, CWF edits colorectal screening claims for age and frequency standards.

4180.8 Medicare Summary Notices (MSNs) and Explanations of Your Part B Medicare Benefits (EOMBs).--Use the following MSN or EOMB messages as appropriate.

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, use the following MSN or EOMB message:

"This service is not covered for beneficiaries under 50 years of age." (MSN Message 18-13, EOMB Message 18-22)

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, use the following MSN or EOMB message:

"Service is being denied because it has not been (12, 24, 48, 120) months since your last (test/procedure) of this kind." (MSN Message 18-14, EOMB Message 18-23)

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

"Medicare only covers this procedure for beneficiaries considered to be at a high risk for colorectal cancer." (MSN Message 18-15, EOMB Message 18-24)

D. If the claim is being denied because payment has already been made for a screening flexible sigmoidoscopy (code G0104), screening colonoscopy (code G0105), or a screening barium enema (codes G0106 or G0120), use the following MSN or EOMB message:

"This service is denied because payment has already been made for a similar procedure within a set timeframe." (MSN Message 18-16, EOMB Message 18-25)

NOTE: The above messages (MSN 18-16 and EOMB 18-25) 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 contains an invalid procedure code, the claim should be returned as unprocessable per MCM §3005.4.

F. If the claim is being denied for a noncovered screening procedure code such as G0122, use the following MSN or EOMB message:

"Medicare does not pay for this item or service." (MSN Message 16.10, EOMB Message 16.17)

4180.9 Remittance Advice Notices.--

A. If the claim for a screening fecal-occult blood test, a screening flexible sigmoidoscopy, or a screening barium enema is being denied because the patient is under 50 years of age, use existing American National Standard Institute (ANSI) X12-835 claim adjustment reason code 6 "the procedure code is inconsistent with the patient's age," at the line level along with line level remark code M82 "Service is not covered when beneficiary is under age 50."

B. If the claim for a screening fecal-occult blood test, a screening colonoscopy, a screening flexible sigmoidoscopy, or a screening barium enema is being denied because the time period between the test/procedure has not passed, use existing ANSI X12-835 claim adjustment reason code 119 "Benefit maximum for this time period has been reached" at the line level.

C. If the claim is being denied for a screening colonoscopy (code G0105) or a screening barium enema (G0120) because the beneficiary is not at a high risk, use existing ANSI X12-835 claim adjustment reason code 46 "This procedure is not covered" at the line level along with line level remark code M83 "Service is not covered unless the beneficiary is classified as a high risk."

D. If the service is being denied because payment has already been made for a similar procedure within the set time frame, use existing ANSI X12-835 claim adjustment reason code 18, "Duplicate claim/service" at the line level along with line level remark code M86 "This service is denied because payment has already been made for a similar procedure within a set timeframe."

E. If the claim is being denied for a noncovered screening procedure such as G0122, use existing ANSI X12-835 claim adjustment reason code 49, "These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam."

4180.10 Ambulatory Surgical Center Facility Fee.--CPT code 45378, which is used to code a diagnostic colonoscopy, is on the list of procedures approved by Medicare for payment of an ambulatory surgical center (ASC) facility fee under §1833(I) of the Act. CPT code 45378 is currently assigned to ASC payment group 2. Code G0105 (colorectal cancer screening; colonoscopy on individual at high risk) has been added to the ASC list effective for services furnished on or after January 1, 1998. Code G0105 is also assigned to ASC payment group 2. The ASC facility service is the same whether the procedure is a screening or a diagnostic colonoscopy.