Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

PQRI Information Available

A new CMS webpage dedicated to providing information on the Physician Quality Reporting Initiative (PQRI) is now available.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the Physician Quality Reporting Initiative. For more information, visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html on the CMS website.

MLN Matters Number: SE0710 | Related Change Request (CR) #: N/A

Related CR Release Date: N/A | Effective Date: N/A

Related CR Transmittal #: N/A | Implementation Date: N/A

Note: This article was updated on August 28, 2012, to reflect current Web addresses. All other information is the same.

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, nurse practitioners, physician assistants, clinical nurse specialists, outpatient hospital departments, and community surgical centers who furnish or provide referrals for and /or file claims for Medicare-covered colorectal cancer screening services.

Provider Action Needed

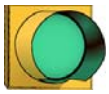
STOP – Impact to You

March is National Colorectal Cancer Awareness Month. The Centers for Medicare & Medicaid Services (CMS) would like to remind providers to encourage their eligible patients, age 50 and older, to get screened for colorectal cancer. This Special Edition *MLN Matters* article highlights coverage changes that became effective January 1, 2007 and reviews Medicare coverage and billing processes for colorectal cancer screening.

Disclaimer
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

Be sure your staff is aware of this coverage and the CMS urges physicians to encourage their patients to take advantage of this important coverage.

Background

Colorectal cancer is the second leading cause of cancer death in the U.S., and the third most common type of cancer. In 2006, colorectal cancer was expected to account for 55,170 deaths and 148,610 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) indicate the Medicare 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. There are insufficient data to determine which screening strategy is best in terms of the balance of benefits and potential harms or cost-effectiveness. Studies reviewed by the USPSTF indicate that colorectal cancer screening is likely to be cost-effective (less than $30,000 per additional year of life gained) regardless of the strategy chosen. To read the full recommendation, go to the following link: http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm on the Web.

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 2 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.

Disclaimer
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.

Risk Factors

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

Coverage Information

Medicare covers the following colorectal cancer screening tests and procedures:

- Fecal occult blood test (FOBT): Medicare covers 1 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 1 FOBT, not both, per year. Beneficiaries do not have to pay coinsurance for the FOBT, and do not have to meet the annual Medicare Part B deductible.

Note: In 2006, and effective for services provided January 1, 2007 and later, CMS adopted the more specific CPT code 82270 (patient was provided 3 single cards or single triple card for consecutive collection) and discontinued the G code G0107 (FOBT, 1-3 simultaneous determinations) to encourage quality colorectal cancer screening practices. Two studies published in January 2005 in the *Annals of Internal Medicine* suggested 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.

- Screening flexible sigmoidoscopy: Medicare covers a screening flexible sigmoidoscopy once every 4 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.

Disclaimer
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.

- 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 1 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 1 screening colonoscopy every 2 years, regardless of age. A screening colonoscopy must be performed by a doctor of medicine or osteopathy.
- Screening barium enema: Medicare covers a screening barium enema as an alternative to a screening flexible sigmoidoscopy for all beneficiaries under the same coverage requirements and at the same frequency as for the screening flexible sigmoidoscopy. Medicare will cover only one such service during the coverage timeframe: it will cover either the screening flexible sigmoidoscopy or the barium enema, but not both.

Medicare also covers a barium enema as an alternative to a screening colonoscopy rendered to a beneficiary at high risk for developing colorectal cancer under the same coverage requirements, at the same frequency. Medicare will cover only one such service during the coverage timeframe: it will cover either the screening colonoscopy for the high-risk beneficiary or the barium enema rendered in lieu of it, but not both.

A screening barium enema must be ordered in writing and collected 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.

The beneficiary is liable for paying 20% of the Medicare-approved amount (the coinsurance) for screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema. See "2007 Changes" for changes to coinsurance amount.

2007 Changes

- Starting January 1, 2007, the Medicare Part B deductible has been waived for screening colonoscopy, sigmoidoscopy, and barium enema (as an alternative to colonoscopy or sigmoidoscopy). However, the deductible is not waived if the colorectal cancer screening test becomes a diagnostic colorectal test; that is the service actually results in a biopsy or removal of a lesion or growth.
- Starting January 1, 2007, for a screening flexible sigmoidoscopy or a screening colonoscopy performed in a non-outpatient prospective payment

Disclaimer
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.

system hospital outpatient department, the beneficiary is liable for paying 25% of the Medicare-approved amount (the coinsurance). The 25% coinsurance is currently being applied in the Outpatient Prospective Payment System (OPPS) for OPPS hospitals. However, it is not being applied to non-OPPS hospitals. Starting January 1, 2007, for a screening colonoscopy performed in an ambulatory surgical center, the beneficiary is liable for paying 25% of the Medicare-approved amount (the coinsurance).

In addition, G0107 (FOBT, 1-3 simultaneous determinations) has been discontinued. CPT code 82270 (patient was provided 3 single cards or single triple card for consecutive collection) has been adopted to encourage quality colorectal cancer screening.

How to Bill Medicare

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

HCPCS/CPT Code	Code Descriptors
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
82270	Colon cancer screening; FOBT, patient was provided 3 single cards or single triple card for consecutive collection
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; fecal occult blood test, immunoassay

* 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 of the Guide to Preventive Services. This guide is available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PSGUID.pdf on the CMS website.

Disclaimer
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.

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

If billing 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 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 associated revenue code is also provided in the colorectal cancer screening chapter of the Guide to Preventive Services. Once again, this guide is available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PSGUID.pdf on the CMS website.

Reimbursement information is also provided in this guide.

Additional Information

- CMS has developed a comprehensive prevention website (http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html 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.
- Other MLN Matters articles on colorectal cancer screening changes mentioned in this special edition are MM5387 (coinsurance changes) http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5387.pdf and MM5127 (deductible change) http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5127.pdf.

Disclaimer
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.

CMS has also developed a variety of educational products and resources to help health care professionals and their staff, become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The web page is located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html on the CMS website.

- The CMS website provides information for each preventive service covered by Medicare. Visit http://www.cms.gov/, select "Medicare", and scroll down to "Prevention".

For products to share with your Medicare patients, visit ***http://www.medicare.gov*** on the Web.

Medicare beneficiaries can obtain information about Medicare preventive benefits at http://www.medicare.gov/ and then click on "Preventive Services". They can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Flu Shot Reminder

It's Not Too Late to Give and Get the Flu Shot!

The peak of flu season typically occurs between late December and March; however, flu season can last until May. **Protect yourself, your patients, and your family and friends by getting and giving the flu shot.** Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination. Remember - influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' website: ***http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf*** .

Disclaimer
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.