CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13921	**Date: August 27, 2026**
	Change Request 14581

SUBJECT: NCD 210.3 Screening for Colorectal Cancer-Non-Invasive Biomarker Tests

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform contractors that CMS has determined that effective June 8, 2026, non-invasive biomarker screening tests are appropriate colorectal cancer screening tests based on specific criteria.

EFFECTIVE DATE: June 8, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2027

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/60/Colorectal Cancer Screening
R	18/60/1/Payment
R	18/60/1/1/Deduction and Coinsurance
R	18/60/2/HCPCS Codes, Frequency Requirements and Age Requirements
R	18/60/2/1/Common Working File (CWF) Edits
R	18/60/6 Billing Requirements for Claims Submitted to A/B (MACs) (A)
R	18/60/7/Medicare Summary Notices (MSN) Messages
R	18/60/8/Remittance Advice Codes

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13921	Date: August 27, 2026	Change Request: 14581

SUBJECT: NCD 210.3 Screening for Colorectal Cancer-Non-Invasive Biomarker Tests

EFFECTIVE DATE: June 8, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2027

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform contractors that CMS has determined that effective June 8, 2026, non-invasive biomarker screening tests are appropriate colorectal cancer screening tests based on specific criteria.

II. GENERAL INFORMATION

A. Background: Sections 1861(s)(2)(R) and 1861(pp) of the Social Security Act (the Act) and regulations at 42 CFR 410.37 authorize Medicare coverage for screening Colorectal Cancer (CRC) tests under Medicare Part B. The statute and regulations authorize the Secretary to add other tests and procedures (and modifications to tests and procedures for colorectal cancer screening) as the Secretary finds appropriate based on consultation with appropriate organizations.

B. Policy: Non-invasivebiomarker colorectal cancer screening testing detects molecular markers shed by colorectal cancer and pre- malignant colorectal epithelial neoplasia into blood, bodily secretions, or directly into the intestinal lumen. Through the use of selective enrichment and amplification techniques, tests are designed to detect very small amounts of markers to identify colorectal cancer or pre-malignant colorectal neoplasia.

Non-Invasive Biomarker tests are covered once every three years under the following conditions.

A. Ordering Criteria

1. When ordered by the physician, physician assistant, nurse practitioner, or clinical nurse specialist who will use the results in the management of the patient.

B. Patient Criteria

1. Age 45 to 85 years; and,
2. Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive non-invasive biomarker colorectal cancer screening test); and,
3. At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn’s Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer); and,
4. Provided with information about the test performance and the importance of a follow-on colonoscopy if the test returns a positive result.

C. Test Criteria

1. The test must be Food and Drug Administration (FDA) market authorized and indicated for colorectal cancer screening; and,
2. The test must achieve the requirements of the FDA-required post-approval study as specified in the Safety and Effectiveness Data (SSED) **to continue coverage**; and
3. The test must be processed in a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory; and,
4. The test must demonstrate performance characteristics that meet **EITHER Criteria1,** a sensitivity of greater than or equal to 90% and a specificity greater than or equal to 87%, **OR Criteria 2,** a sensitivity of greater than or equal to 79% and a specificity of greater than or equal to 90% in the detection of colorectal cancer compared to the recognized standard (accepted as colonoscopy at this time), based on the FDA labeling.

	Test PerformanceCriteria 1	**Test Performance Criteria 2**
Sensitivity for CRC	≥ 90%	≥ 79%
Specificity for CRC	≥ 87%	≥ 90%

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	**Requirement**	**Responsibility**								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14581 - 04.1	Contractors shall accept and pay for non-invasive biomarker screening tests as a covered service when they meet the National Coverage Determination (NCD) criteria. Please refer to Pub. 100-03 NCD Manual, Section 210.3 for further coverage policy and Pub. 100-04 Claims Processing Manual, Chapter 18, Section 60, for updated claims processing instructions.	X	X							
14581 - 04.2	Contractors shall accept and pay for colorectal screening test, (ColosenseTM) Healthcare Common Procedure Coding System	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	(HCPCS) 0421U as a covered service. NOTE: Refer to Publication (Pub.) 100-03, Medicare National Coverage Determination Manual, Chapter 1, Section 210.3 for coverage policy, and Pub. 100-04, Claims Processing Manual, Chapter 18, Section 60, for updated claims processing instructions.									
14581 - 04.3	Contractors shall waive the Medicare deductible and coinsurance for HCPCS 0421U. NOTE: For institutional claims, since this HCPCS code is billed under the clinical laboratory fee schedule, the system shall automatically suppress coinsurance and deductible.		X			X				
14581 - 04.4	Contractors shall update editing to deny line-items on claims containing HCPCS 0421U when reported more than once in a 3-year period [at least 2 years and 11 full months (35 months total) must elapse from the date of the last screening].		X			X			X	
14581 - 04.4.1	Contractors shall use the following messages when denying line-items: CARC 119: “Benefit maximum for this time period or occurrence has been reached.”		X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp If you do not have web access, you may contact the contractor to request a copy of the NCD." MSN 15.20: "The following policies NCD 210.3 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.3 fueron utilizadas cuando se tomó esta decisión." Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227). Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.									
14581 - 04.5	Contractors shall update editing to deny line-items on claims containing HCPCS code 0421U when the beneficiary is not between the ages of 45-85 on the date of		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	service.									
14581 - 04.5.1	Contractors shall use the following messages when denying a line-item: CARC 6: The procedure/revenue code is inconsistent with the patient's age. RARC N129: Not eligible due to the patient's age. MSN 15.20: "The following policies NCD 210.3 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.3 fueron utilizadas cuando se tomó esta decisión." Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.		X							
14581 - 04.6	Contractors shall create/update editing to only allow HCPCS code 0421U on Type of Bills (TOBs), 013X, 014X, or 085X to Return to Provider (RTP).					X				
14581 - 04.6.1	Contractors shall RTP claims.	X								
14581 - 04.7	Contractors shall calculate the next eligible date for HCPCS 0421U for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status • Beneficiary claims history								X	CVM, MBD, NGD

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• Utilization rules NOTE: The calculation for preventive services next eligible date shall parallel claims processing.									
14581 - 04.7.1	Contractors shall display the next eligible dates on all Common Working File (CWF) provider query screens (HUQA and PRVN).					X			X	MBD, NGD
14581 - 04.7.2	Contractors shall display this information in the date field to indicate why there is not a next eligible date, when there is no next eligible date on the CWF provider query screens.								X	MBD, NGD
14581 - 04.7.3	Contractors shall display and update changes to beneficiary master data or claims data that would result in a change to any next eligible date.								X	HETS, MBD, NGD
14581 - 04.7.4	Contractors shall modify the HICR transaction HCSR to include the HCPCS 0421U								X	
14581 - 04.7.5	Contractors shall create a one-time utility to capture all beneficiaries that have a colorectal screening test, HCPCS 0421U from June 8, 2026, to the implementation date of this CR.								X	
14581 - 04.7.5.1	Contractors shall create a one-time refresh to MBD/NGD/HETS to capture all beneficiaries that have a colorectal screening test, HCPCS 0421U from June 8, 2026 to the implementation date of this CR.								X	HETS, MBD, NGD
14581 - 04.8	The Multi-Carrier System Desktop Tool (MCSDT) shall		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	display HCPCS 0421U sessions on a separate screen and in a format equivalent to the CWF HIMR screen.									
14581 - 04.9	Contractors shall update editing for HCPCS 0421U to require diagnosis code Z12.11 or Z12.12 to be on claims.					X				
14581 - 04.10	Contractors shall update editing to require diagnosis code Z12.11 or Z12.12 for the following HCPCS: 81528 and 0537U.					X				
14581 - 04.11	Contractors shall not search for claims containing HCPCS 0421U with dates of service on or after June 8, 2026, but contractors may adjust claims that are brought to their attention.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B, A/B MAC Part HHH, DME MAC

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

60 - Colorectal Cancer Screening

(Rev.13921; Issued: 08-27-26; Effective: 06-08-26; Implementation: 01-04-27)

See the Medicare Benefit Policy Manual, Chapter 15, and the Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Section 210.3 for Medicare Part B coverage requirements and effective dates of colorectal cancer screening services.

Effective for services furnished on or after January 1, 1998, payment may be made for colorectal cancer screening for the early detection of cancer. For screening colonoscopy services (one of the types of services included in this benefit) prior to July 2001, coverage was limited to high-risk individuals. For services July 1, 2001, and later, screening colonoscopies are covered for individuals not at high risk.

The following services are considered colorectal cancer screening services:

- *Colonoscopy;*
- *Computed Tomography (CT) Colonography;*
- *Flexible sigmoidoscopy;*
- *Fecal-occult blood test (FOBT), 1-3 simultaneous determinations (guaiac-based); and*
- *Non-Invasive Biomarker test.*

Effective for services on or after January 1, 2004, payment may be made for the following colorectal cancer screening service as an alternative for the guaiac-based FOBT, 1-3 simultaneous determinations:

- FOBT, immunoassay, 1-3 simultaneous determinations

Effective for services on or after October 9, 2014, payment may be made for colorectal cancer screening using the Cologuard™ multi-target sDNA test:

- CPT code 81528, Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result, effective January 2, 2016**.**

Effective for services on or after January 19, 2021, payment may be made for colorectal cancer using Blood-based DNA Testing:

- Blood-based Biomarker Test, HCPCS G0327, effective July 1, 2021

Effective for services on or after October 3, 2024, payment may be made for Cologuard Plus (CPT code 0464U).

Effective for services on or after January 1, 2025, payment may be made for colorectal cancer screening using Computed Tomography (CT) Colonography (CPT code 74263).

Effective for services or after January 1, 2025, Barium enema (HCPCS G0106 and G0120) is no longer a covered service.

Effective for services on or after April 1, 2025, payment may be made for Shield (CPT code 0537U).

Effective for services on or after June 8, 2026, payment may be made for ColoSense (CPT code 0421U).

60.1 - Payment

(Rev.13921; Issued: 08-27-26; Effective: 06-08-26; Implementation: 01-04-27)

Payment is under the MPFS except as follows:

- FOBTs CPT code 82270 and HCPCS G0328 are paid under the CLFS except reasonable cost is paid to all non-outpatient prospective payment system (OPPS) hospitals, including Critical Access Hospitals (CAHs), IHS hospitals (billing on TOB 013X) are paid the Office of Management and Budget (OMB)-approved all-inclusive rate (AIR), or the facility specific per visit amount as applicable. Deductible and coinsurance do not apply for these tests. See section A below for payment to Maryland waiver hospitals on TOB 013X. Payment to all hospitals for non-patient laboratory specimens on TOB 014X will be based on the CLFS, including CAHs and Maryland waiver hospitals.

- For claims with dates of service on or after January 1, 2016, CPT code 81528 is paid under the CLFS.

- For claims with dates of service on or after January 19, 2021, Blood-based Biomarker test (HCPCS G0327) is paid under the CLFS.

- *For claims with dates of service on or after October 3, 2024, Cologuard Plus (CPT code 0464U) is paid under the CLFS.*
- *For claims with dates of service on or after April 1, 2025, Shield (CPT code 0537U) is paid under the CLFS.*

- *For claims with dates of service on or after June 8, 2026, ColoSense (CPT code 0421U) is paid under the CLFS.*
- Flexible sigmoidoscopy *(HCPCS* G0104) is paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs; or current payment methodologies for hospitals not subject to OPPS.

- Colonoscopies (HCPCS G0105 and G0121) are paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs or current payment methodologies for hospitals not subject to OPPS. The following screening codes must be paid at rates consistent with the rates of the diagnostic codes indicated. Coinsurance and deductible apply to diagnostic codes.

HCPCS Screening Code	**CPT Diagnostic Code**
G0104	45330
G0105 and G0121	45378

- *For claims with dates of service on or after January 1, 2025, Computed Tomography (CT) Colonography (CPT code 74263) is paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs; or current payment methodologies for hospitals not subject to OPPS.*

A. Special Payment Instructions for TOB 013X Maryland Waiver Hospitals

For hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission, screening colorectal services HCPCS G0104, G0105, G0121, G0328, and *G0327 and CPT* codes 82270, 74263, 81528*, 0464U, 0421U, and 0537U* 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 013X for outpatient colorectal cancer screenings.

B. Special Payment Instructions for Non-Patient Laboratory Specimen (TOB 014X) for All Hospitals

Payment for colorectal cancer screenings CPT codes 82270, 74263, *81528, 0464U, 0421U, 0537U and* HCPCS G0328 and G0327 to a hospital for a non-patient laboratory specimen (TOB 014X), 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.

Effective for services or after January 1, 2025, Barium enema (HCPCS G0106 and G0120) is no longer a covered service.

60.1.1 – Deductible and Coinsurance

(Rev.13921; Issued: 08-27-26; Effective: 06-08-26; Implementation: 01-04-27)

There is no deductible and no coinsurance or copayment for the FOBTs (CPT code 82270 and HCPCS G0328), flexible sigmoidoscopies (*HCPCS* G0104), colonoscopies on individuals at high risk (HCPCS G0105), or colonoscopies on individuals not meeting criteria of high risk (HCPCS G0121).

Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the -PT modifier; and the deductible is waived. Prior to January 1, 2022, when a screening colonoscopy became a diagnostic, the beneficiary was liable for the full applicable coinsurance. However, Section 122 of Division CC of the Consolidated Appropriations Act (CAA) of 2021, Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests, amended section 1833(a) of the Social Security Act to offer a special coinsurance rule for screening flexible sigmoidoscopies and screening colonoscopies, regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure, that is furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test. Consequently, the applicable coinsurance in these specific scenarios will be gradually reduced until it is completely waived for dates of service on or after January 1, 2030. Specifically, for dates of service in CY 2023 through CY 2026, when the PT modifier is appended to at least one code on the claim to indicate that a screening colorectal cancer procedure, HCPCS G0104, G0105, or G0121, has become a diagnostic or therapeutic service, contractors shall continue to waive deductible and shall apply a reduced coinsurance of 15% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service in CY 2027 through CY 2029, contractors shall continue to waive deductible and shall apply a reduced coinsurance of 10% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service on or after January 1, 2030, contractors shall continue to waive deductible and shall waive coinsurance for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim.

Coinsurance and deductible are waived for moderate sedation services (reported with HCPCS G0500 or CPT code 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier -33. When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (HCPCS G0500 or CPT code 99153) are reported with only the -PT modifier; only the deductible is waived.

Prior to January 1, 2007, deductible and coinsurance apply to other colorectal procedures (HCPCS G0106 and G0120). After January 1, 2007, the deductible is waived for those tests. Coinsurance applies.

Effective for claims with dates of service on and after October 9, 2014, deductible and coinsurance do not apply to the Cologuard™ multi-target sDNA screening test CPT code 81528).

Effective for claims with dates of service on and after January 19, 2021, deductible and coinsurance do not apply to the Blood-based biomarker test (HCPCS G0327).

Effective for claims with dates of service on and after October 3, 2024, deductible and coinsurance do not apply to Cologuard Plus (CPT code 0464U).

Effective for claims with dates of service on or after January 1, 2025, deductible and coinsurance do not apply to CT Colonography (CPT code74263).

Effective for claims with dates of service on and after April 1, 2025, deductible and coinsurance do not apply to Shield (CPT code 0537U).

Effective for claims with dates of service on and after June 8, 2026, deductible and coinsurance do not apply

to ColoSense (CPT code 0421U).

Note: For institutional claims, since HCPCS G0327 and CPT codes 81528, 0464U, 0421U, and 0537U are billed under the clinical laboratory fee schedule, the system shall automatically suppress coinsurance and deductible.

Effective for claims with dates of service on or after January 1, 2023, colorectal cancer screening tests include a screening colonoscopy (HCPCS G0105 and G0121) that follows a non-invasive stool- based test (CPT *codes* 82270, 81528, *0464U, and 0421U and HCPCS* G0328). This scenario shall be identified by the furnishing practitioner by including the KX modifier on the screening colonoscopy claim. Deductible and coinsurance do not apply to the non-invasive stool-based tests nor the screening colonoscopy because both tests are specified preventive screening services.

Effective for claims with dates of service on or after January 1, 2025, colorectal cancer screening tests include a screening colonoscopy (HCPCS G0105 and G0121) that follows a non-invasive blood- based test (HCPCS G0327 and CPT code 0537U). This scenario shall be identified by the furnishing practitioner by including the KX modifier on the screening colonoscopy claim. Deductible and coinsurance do not apply to the non-invasive blood-based tests nor the screening colonoscopy because both tests are specified preventive screening services.

60.2 - HCPCS Codes, Frequency Requirements, and Age Requirements

(Rev.13921; Issued: 08-27-26; Effective: 06-08-26; Implementation: 01-04-27)

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

- CPT code 82270 - Colorectal cancer screening; fecal-occult blood tests, 1-3 simultaneous determinations;
- HCPCS G0104 - Colorectal cancer screening; flexible sigmoidoscopy;

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

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

Effective for services furnished on or after January 1, 2004, the following code is added for colorectal cancer screening services as an alternative to CPT 82270:

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

Effective for services furnished on or after January 1, 2025, the following code is added for colorectal cancer screening services:

- *CPT code 74263 – Computed Tomographic (CT) Colonography, screening, including image postprocessing*

Non-invasive Biomarker Screening Tests:

Effective for services furnished on or after January1,2016, the following code is added for colorectal cancer screening services:

CPT code 81528 -Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result, .

Effective for services furnished on or after January 19, 2021, the following code is added for colorectal cancer *screening* services:

- HCPCS G0327 - Colorectal cancer screening; blood-based biomarker Colon ca scrn;bld-bsd biomrk

Effective for services furnished on or after October 3, 2024, the following code is added for colorectal cancer screening services:

- *CPT code 0464U - Oncology (colorectal) screening, quantitative real-time target and signal amplification, methylated DNA markers, including LASS4, LRRC4 and PPP2R5C, a reference marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result*

Effective for services furnished on or after April 1, 2025, the following code is added for colorectal cancer screening services:

- *CPT code 0537U - Oncology (colorectal cancer), analysis of cell-free DNA for epigenomic patterns, next-generation sequencing, >2,500 differentially methylated regions (DMRs), plasma, algorithm reported as positive or negative*

Effective for services furnished on or after June 8, 2026, the following code is added for colorectal cancer screening services:

- *CPT code 0421U - Oncology (colorectal) screening, quantitative real-time target and signal amplification of 8 RNA markers (GAPDH, SMAD4, ACY1, AREG, CDH1, KRAS, TNFRSF10B, EGLN2) and fecal hemoglobin, algorithm reported as a positive or negative for colorectal cancer risk*

Effective for claims with dates of service on or after January 1, 2023, the frequency limitations for screening colonoscopy (HCPCS G0105 and G0121) shall not apply when the screening colonoscopy follows a positive result from a non-invasive stool-based test (HCPCS G0328 and CPT codes 82270, *81528, 0464U, and 0421U*). This scenario is identified when the furnishing practitioner submits the screening colonoscopy claim with the KX modifier. See 42 CFR 410.37(k).

Effective for claims with dates of service on or after January 1, 2025, the frequency limitations for screening colonoscopy (HCPCS G0105 and G0121) shall not apply when the screening colonoscopy follows a positive result from a non-invasive blood-based test (HCPCS G0327 and CPT code 0537U). This scenario is identified when the furnishing practitioner submits the screening colonoscopy claim with the KX modifier. See 42 CFR 410.37(k).

G0104 – Colorectal Cancer Screening; Flexible Sigmoidoscopy

Screening flexible sigmoidoscopies (HCPCS 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, A/B MACs (A) and (B) pay for screening flexible sigmoidoscopies (HCPCS 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 (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) (as defined in §1861(aa)(5) of the Social Security Act (the Act) and in the Code of Federal Regulations (CFR) 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, Medicare Administrative Contractors (MACs) 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 performed).

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 (HCPCS 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 (HCPCS G0121).

Effective for claims with dates of service on or after January 1, 2023, the minimum age for screening flexible sigmoidoscopy is reduced to 45 years and older.

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 along with modifier -PT should be billed and paid rather than HCPCS G0104.

HCPCS G0105 – Colorectal Cancer; Colonoscopy on Individual at High Risk

Screening colonoscopies (HCPCS 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 HCPCS 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 along with modifier -PT should be billed and paid rather than HCPCS G0105.

A. Colonoscopy Cannot be Completed Because of Extenuating Circumstances

1. A/B MACs (A)

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 the Common Working File (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.

Use of HCPCS codes with a modifier of -73 or -74 is 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 CAH has elected payment Method II for CAH patients, payment shall be consistent with payment methodologies currently in place as outlined in chapter 3 of this manual. 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 A/B MAC (A) to document the incomplete procedure.

2. A/B MACs (B)

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances (see chapter 12, section 30.1), Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes. The MPFS database has specific values for codes 44388-53, 45378-53, G0105-53 and G0121-53. 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, ASCs) are to suffix the colonoscopy code with modifier -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 A/B MAC (B) to document the incomplete procedure.

*CPT code **74263 – CT Colonography***

Effective for dates of service on or after January 1, 2025, CT Colonography is covered as an appropriate colorectal cancer screening procedure, when ordered by a treating physician and when all of the following requirements are met:

The patient is:

- *age 45 or older and,*

•asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac FOBT or fecal immunochemical test), and,

•at average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer),
And:
•once in a 5-year period (at least 59 months have passed following the month in which the last screening computed tomography colonography was performed) for not at high-risk beneficiaries,
•once in a 4-year period (at least 47 months have passed following the month in which the last flexible sigmoidoscopy or screening colonoscopy was performed) for not at high-risk beneficiaries'
•once in a 2-year period (at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed for high-risk beneficiaries
And:
At least one of the high-risk ICD-10 diagnosis codes from List 1 of the coding spreadsheet for NCD 210.3 is reported on the claim.

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

Effective January 1, 2025, Barium Enema (HCPCS G0106 and G0120) is no longer covered by Medicare.

CPT code 82270 **– Colorectal Cancer Screening; FOBT, 1-3 Simultaneous Determinations**

Effective for services furnished on or after January 1, 1998, screening FOBT (CPT 82270) 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, or effective for dates of service on or after January 27, 2014, the beneficiary's attending physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). (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 an immunoassay-based FOBT (HCPCS G0328, described below) as an alternative to the guaiac-based FOBT, CPT code 82270. Medicare will pay for only one covered FOBT per year, either CPT code 82270 or HCPCS G0328, but not both.

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; FOBT, 1-3 Simultaneous Determinations is reduced to 45 years and older.

HCPCS G0328 – Colorectal Cancer Screening; Immunoassay, FOBT, 1-3 Simultaneous Determinations

Effective for services furnished on or after January 1, 2004, screening FOBT, (HCPCS G0328) may be paid as an alternative to CPT code 82270 for beneficiaries who have attained age 50. Medicare will pay for a covered FOBT (either CPT code 82270 or HCPCS 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, or effective for claims with dates of service on or after January 27, 2014, the beneficiary's attending PA, NP, or CNS. (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 claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; Immunoassay, FOBT, 1-3 Simultaneous Determinations is reduced to 45 years and older.

HCPCS G0121 – Colorectal Cancer 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 (HCPCS 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 HCPCS G0121 screening colonoscopy was performed.)

- If the individual would otherwise qualify to have covered a HCPCS G0121 screening colonoscopy based on the above **but** has had a covered screening flexible sigmoidoscopy (HCPCS G0104), then he or she may have covered a HCPCS G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered HCPCS 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 along with modifier -PT should be billed and paid rather than HCPCS G0121.

Non-invasive Biomarker Screening Tests:

Effective for dates of service on or after June 8, 2026, non-invasive biomarker colorectal cancer screening tests are covered once every 3 years for Medicare beneficiaries that meet all of the following criteria:

Ordering Criteria

- *When ordered by the physician, physician assistant, nurse practitioner, or clinical nurse specialist who will use the results in the management of the patient.*

Patient Criteria

- *Age 45 to 85 years; and,*
- *Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive non-invasive biomarker colorectal cancer screening test); and,*
- *At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer); and,*
- *Provided with information about the test performance and the importance of a follow-on colonoscopy if the test returns a positive result.*

Test Criteria

- *The test must be Food and Drug Administration (FDA) market authorized and indicated for colorectal cancer screening; and,*
- *The test must achieve the requirements of the FDA-required post-approval study as specified in the Safety and Effectiveness Data (SSED) to continue coverage; and*
- *The test must be processed in a CLIA certified laboratory; and*
- *The test must demonstrate performance characteristics that meet EITHER Criteria 1, a sensitivity of greater than or equal to 90% and a specificity greater than or equal to 87%, OR Criteria 2, a sensitivity of greater than or equal to 79% and a specificity of greater than or equal to 90% in the detection of colorectal cancer compared to the recognized standard (accepted as colonoscopy at this time), based on the FDA labeling.*

	Test Performance Criteria 1	*Test Performance Criteria 2*
Sensitivity for CRC	*≥ 90%*	*≥ 79%*
Specificity for CRC	*≥ 87%*	*≥ 90%*

Covered Non-invasive Biomarker Screening Tests:

- *CPT code 81528 - Multitarget sDNA Colorectal Cancer Screening Test - Cologuard*
- *CPT code 0464U Cologuard Plus*
- *CPT code 0421U – ColoSense*
- *HCPCS G0327- Colorectal Cancer Screening - Blood-based Biomarker Tests*
- *CPT code 0537U – Shield*

Providers shall report at least ONE of the following diagnosis codes when submitting claims for a non-invasive biomarker test:

Z12.11-Encounter for screening for malignant neoplasm of colon, OR,

Z12.12-Encounter for screening for malignant neoplasm of rectum

NOTE: A follow-on screening colonoscopy to a non-invasive stool-based or blood-based biomarker test is considered part of a "complete CRCScreening" with no beneficiary cost sharing.

60.2.1 - Common Working Files (CWF) Edits

(Rev.13921; Issued: 08-27-26; Effective: 06-08-26; Implementation: 01-04-27)

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 A/B MAC (A) claims for valid procedure codes (HCPCS G0104, G0105, , G0121, G0122, G0328, and G0327 and CPT codes 82270, 0537U, 0421U, 0464U, and81528 . The CWF currently edits for valid CPT code/HCPCS for A/B/MACs (B). (See §60.6 of this chapter for TOBs.) *Effective 01/01/2025, CWF will edit procedure code 74263 for age and frequency standards.*

60.5 - Noncovered Services

(Rev.13921; Issued: 08-27-26; Effective: 06-08-26; Implementation: 01-04-27)

The following non-covered 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

HCPCS G0121 (colorectal cancer; 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 non-covered 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

*HCPCS*G0122 (colorectal cancer; barium enema) should be used when a screening barium enema is performed **not** as an alternative to either a screening colonoscopy (HCPCS G0105) or a screening flexible sigmoidoscopy (HCPCS G0104). This service should be denied as non-covered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

C. On or after January 1, 2025

HCPCS G0106 and G0120 (colorectal cancer; barium enema) are no longer covered. The beneficiary is liable for payment.

60.6 - Billing Requirements for Claims Submitted to A/B MACs (A)

(Rev.13921; Issued: 08-27-26; Effective: 06-08-26; Implementation: 01-04-27)

Follow the general bill review instructions in chapter 25. Hospitals use the ASC X12 837 institutional claim format to bill the A/B MAC (A) or the hardcopy Form CMS-1450 (UB-04). Hospitals bill revenue codes and HCPCS codes as follows:

Screening Tests/Procedures	**Revenue Codes**	**CPT codes/HCPCS**	**TOBs**
FOBT	030X	82270 , G0328	12X, 13X, 14X**, 22X, 23X, 83X, 85X
Flexible Sigmoidoscopy	*	G0104	12X, 13X, 22X, 23X, 85X****
Colonoscopy-high risk	*	G0105, G0121	12X, 13X, 22X, 23X, 85X****
CT Colonography	*030X*	*74263*	12X, 13X 85X
Non-invasive biomarker test: Multitarget sDNA - Cologuard™	030X	81528	13X, 14X** 85X
Non-invasive biomarker test: Cologuard Plus	*030X*	*0464U*	*13X, 14X** 85X*
Non-invasive biomarker test: ColoSense	*030X*	*0421U*	*13X, 14X** 85X*
Non-invasive biomarker test: Blood-based Biomarker	030X	G0327	13X, 14X** 85X
Non-invasive biomarker test: Shield	*030X*	*0537U*	13X, 14X** 85X

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

** 014X is only applicable for non-patient laboratory specimens.

***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.

****_Effective January 1, 2025, Barium enema (HCPCS G0106 and G0120) is no longer covered by Medicare._

Special Billing Instructions for Hospital Inpatients

When these tests/procedures are provided to inpatients of a hospital or when Part A benefits have been exhausted, they are covered under this benefit. However, the provider bills on TOB 012X using the discharge date of the hospital stay to avoid editing in CWF as a result of the hospital bundling rules.

60.7 - Medicare Summary Notice (MSN) Messages

(Rev.13921; Issued: 08-27-26; Effective: 06-08-26; Implementation: 01-04-27)

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

A. If a claim for a screening FOBT, a screening flexible sigmoidoscopy, is being denied because of the age of the beneficiary, use:

18.29 - This service is not covered for people under 45 years of age.

Spanish Version- “Este servicio no está cubierto para las personas menores de 45 años.”

B. If the claim for a screening FOBT, a screening colonoscopy, a screening flexible sigmoidoscopy, is being denied because the time period between the same test or procedure has not passed, use:

18.14 - 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 because the beneficiary is not at a high risk, use:

18.15 - Medicare covers this procedure only for people 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 FOBT (CPT code 82270 or HCPCS G0328), flexible sigmoidoscopy (HCPCS G0104), screening colonoscopy (HCPCS G0105) use:

18.16 - 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.

E. If the claim is being denied for a non-covered screening procedure code such as HCPCS G0122, use:

16.10 - 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.

F. If denying claims for Cologuard™ multi-target sDNA screening test (CPT code 81528), *Cologuard Plus (CPT code 0464U), ColoSense (CPT code 0421U), Blood-based Biomarker test (HCPCS G0327) or Shield (CPT code 0537U)* when furnished more than once in a 3-year period [at least 2 years and 11 full months (35 months total) must elapse from the date of the last screening], use:

15.20 - The following policies NCD 210.3 were used when we made this decision

Spanish Version – "Las siguientes políticas NCD210.3 fueron utilizadas cuando se tomó esta decisión"

G. If denying claims for Cologuard™ multi-target sDNA screening test (CPT code 81528), *Cologuard Plus (CPT code 0464U), ColoSense (CPT code0421U)*, Blood-based Biomarker test (HCPCS G0327),*or Shield (CPT code 0537U)* because the beneficiary is not between the ages of 45 and 85, use:

15.20 - The following policies NCD 210.3 were used when we made this decision.

Spanish Version – "Las siguientes políticas NCD 210.3 fueron utilizadas cuando se tomó esta decision."

H. If denying claims for Cologuard™ multi-target sDNA screening test (CPT code 81528), *Cologuard Plus (CPT code 0464U), ColoSense (CPT code 0421U), Blood*-based Biomarker test (HCPCS G0327) *or Shield (CPT code 0537U)* because the claim does not contain all of the ICD-10 diagnosis codes required, use:

15.20 - The following policies 210.3 were used when we made this decision

Spanish Version – "Las siguientes políticas NCD210.3 fueron utilizadas cuando se tomó esta decisión"

If denying claims for CT Colonography CPT code 74263 because the claim did not contain the required ICD-10 diagnosis claims, use:

MSN 15.4 – The information provided does not support the need for this service or item.

Spanish Version – La informacion proporcionada no confirma la necesidad para este servicio o articulo

60.8 - Remittance Advice Codes

(Rev.13921; Issued: 08-27-26; Effective: 06-08-26; Implementation: 01-04-27)

All messages refer to ANSI X12N 835 coding.

A. If the claim for a screening FOBT, a screening flexible sigmoidoscopy is being denied because the patient is less than 45 years of age, use:

Claim Adjustment Reason Code (CARC) 6 "The procedure/revenue code is inconsistent with the patient's age," at the line level; and, Remittance Advice Remark Code (RARC) N129 "Not eligible due to patient's age"

B. If the claim for a screening FOBT, a screening colonoscopy, a screening flexible sigmoidoscopy is being denied because the time period between the test/procedure has not passed, use:

CARC 119 "Benefit maximum for this time period or occurrence has been reached" at the line level.

C. If the claim is being denied for a screening colonoscopy (HCPCS G0105) because the patient is not at a high risk, use:

CARC 46 "This (these) service(s) is (are) not covered" at the line level; and,

RARC M83 "Service is not covered unless the patient is classified as a high risk." at the line level.

D. If the service is being denied because payment has already been made for a similar procedure within the set time frame, use:

CARC 18, "Duplicate claim/service" at the line level; and,

RARC M86 "Service is denied because payment already made for similar procedure within a set timeframe." at the line level.

E. If the claim is being denied for a non-covered screening procedure such as HCPCS G0122, use:

CARC 49, "These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam."

F. If the claim is being denied because the code is invalid, use the following at the line level:

CARC B18 "Payment denied because this procedure code/modifier was invalid on the date of service or claim submission."

G. If denying claims for Cologuard™ multi-target sDNA screening test (CPT code 81528), *Cologuard Plus (CPT code 0464U), ColoSense (CPT code 0421U), Blood-based Biomarker test (HCPCS G0327) or Shield (CPT code 0537U)* when furnished more than once in a 3-year period [at least 2 years and 11 full months (35 months total) must elapse from the date of the last screening], use:

CARC 119: "Benefit maximum for this time period or occurrence has been reached."

RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

H. If denying claims for Cologuard™ multi-target sDNA screening test (CPT code 81528), *Cologuard Plus (CPT code 0464U), ColoSense (CPT code 0421U),* Blood-based Biomarker test (HCPCS G0327) *or Shield (CPT code 0537U)* when beneficiary is not between the ages 45-85, use:

CARC 6: "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

RARC N129: "Not eligible due to the patient's age."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

I. If denying claims for Cologuard™ multi-target sDNA screening test(CPT code 81528), *Cologuard Plus (CPT code 0464U), ColoSense (CPT code 0421U),* Blood-based Biomarker test (HCPCS G0327) *or Shield (CPT code 0537U)* when the claim does not contain ICD-10 diagnosis codes Z12.12 OR Z12.11), use:

CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

J. If denying a CT Colonography claim line-item for frequency requirement reasons, contractors shall use the following messages:

CARC 119: "Benefit maximum for this time period or occurrence has been reached."

RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp

If you do not have web access, you may contact the contractor to request a copy of the NCD."

MSN 15.20: "The following policies NCD 210.3 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.3 fueron utilizadas cuando se tomó esta decisión."

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633- 4227).
Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

K. *If denying a CT Colonography claim line-item when the beneficiary's age is not 45 or older, contractors shall use the following messages:*

CARC 6 – The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF), if present.

RARC N129 – Not eligible due to patient's age.

Group Code – CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the item).

MSN 15.4 – The information provided does not support the need for this service or item.

Spanish Version – La informacion proporcionada no confirma la necesidad para este servicio o articulo.

L. *If denying a CT Colonography claim line-item when the claim submitted with the incorrect diagnosis(ses) codes(s), contractors shall use the following messages:*

CARC 11- (The diagnosis is inconsistent with the procedure)

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at: www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

MSN 15.20 - "The following polices were used when we made this decision: NCD 270.3."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

NCD:	210.3
NCD Title:	Colorectal Cancer Screening Tests
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf
ICD-10 CM	**ICD-10 DX Description**
	CMS reserves the right to add or remove diagnosis codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy.
	There are two lists below: **List 1: Partial List of Dx Codes Indicating High Risk: Only applicable to G0105 and G0120 (high risk colorectal screening).** End date G0120 effective 12/31/2024. Add coverage for 74263 effective 1/1/2025 for high risk patients. **List 2: Applicable to 81528 (Cologuard), 0421U (Colosense™), 0464U (Cologuard Plus™), 0537U(Shield™), and G0327 (Blood-based Biomarker Tests).** Add coverage for 74263 effective 1/1/2025 for patients not at high risk.
LIST 1: Partial List of Dx Codes Indicating High Risk: Only applicable to G0105 and G0120 (high risk colorectal screening)	
	End date G0120 effective 12/31/2024.
	Add coverage for 74263 effective 1/1/2025 for patients at high risk.
C18.0	Malignant neoplasm of cecum
C18.2	Malignant neoplasm of ascending colon
C18.3	Malignant neoplasm of hepatic flexure
C18.4	Malignant neoplasm of transverse colon
C18.5	Malignant neoplasm of splenic flexure
C18.6	Malignant neoplasm of descending colon
C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21.0	Malignant neoplasm of anus, unspecified
C21.1	Malignant neoplasm of anal canal
C21.2	Malignant neoplasm of cloacogenic zone
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C49.A3	Gastrointestinal stromal tumor of small intestine
C49.A4	Gastrointestinal stromal tumor of large intestine
C49.A5	Gastrointestinal stromal tumor of rectum
C78.5	Secondary malignant neoplasm of large intestine and rectum
C7A.021	Malignant carcinoid tumor of the cecum
C7A.022	Malignant carcinoid tumor of the ascending colon
C7A.023	Malignant carcinoid tumor of the transverse colon
C7A.024	Malignant carcinoid tumor of the descending colon
C7A.025	Malignant carcinoid tumor of the sigmoid colon
C7A.026	Malignant carcinoid tumor of the rectum
D01.0	Carcinoma in situ of colon
D01.1	Carcinoma in situ of rectosigmoid junction
D01.2	Carcinoma in situ of rectum
D01.3	Carcinoma in situ of anus and anal canal
D12.0	Benign neoplasm of cecum
D12.2	Benign neoplasm of ascending colon
D12.3	Benign neoplasm of transverse colon

ICD-10 CM	ICD-10 DX Description
D12.4	Benign neoplasm of descending colon
D12.5	Benign neoplasm of sigmoid colon
D12.7	Benign neoplasm of rectosigmoid junction
D12.8	Benign neoplasm of rectum
D12.9	Benign neoplasm of anus and anal canal
D37.4	Neoplasm of uncertain behavior of colon
D37.5	Neoplasm of uncertain behavior of rectum
D37.9	Neoplasm of uncertain behavior of digestive organ, unspecified
D3A.021	Benign carcinoid tumor of the cecum
D3A.022	Benign carcinoid tumor of the ascending colon
D3A.023	Benign carcinoid tumor of the transverse colon
D3A.024	Benign carcinoid tumor of the descending colon
D3A.025	Benign carcinoid tumor of the sigmoid colon
D3A.026	Benign carcinoid tumor of the rectum
D3A.029	Benign carcinoid tumor of the large intestine, unspecified portion
K50.00	Crohn's disease of small intestine without complications
K50.011	Crohn's disease of small intestine with rectal bleeding
K50.012	Crohn's disease of small intestine with intestinal obstruction
K50.013	Crohn's disease of small intestine with fistula
K50.014	Crohn's disease of small intestine with abscess
K50.018	Crohn's disease of small intestine with other complication
K50.019	Crohn's disease of small intestine with unspecified complications
K50.10	Crohn's disease of large intestine without complications
K50.111	Crohn's disease of large intestine with rectal bleeding
K50.112	Crohn's disease of large intestine with intestinal obstruction
K50.113	Crohn's disease of large intestine with fistula
K50.114	Crohn's disease of large intestine with abscess
K50.118	Crohn's disease of large intestine with other complication
K50.119	Crohn's disease of large intestine with unspecified complications
K50.80	Crohn's disease of both small and large intestine without complications
K50.811	Crohn's disease of both small and large intestine with rectal bleeding
K50.812	Crohn's disease of both small and large intestine with intestinal obstruction
K50.813	Crohn's disease of both small and large intestine with fistula
K50.814	Crohn's disease of both small and large intestine with abscess
K50.818	Crohn's disease of both small and large intestine with other complication
K50.819	Crohn's disease of both small and large intestine with unspecified complications
K50.90	Crohn's disease, unspecified, without complications
K50.911	Crohn's disease, unspecified, with rectal bleeding
K50.912	Crohn's disease, unspecified, with intestinal obstruction
K50.913	Crohn's disease, unspecified, with fistula
K50.914	Crohn's disease, unspecified, with abscess
K50.918	Crohn's disease, unspecified, with other complication
K50.919	Crohn's disease, unspecified, with unspecified complications
K51.00	Ulcerative (chronic) pancolitis without complications
K51.011	Ulcerative (chronic) pancolitis with rectal bleeding
K51.012	Ulcerative (chronic) pancolitis with intestinal obstruction
K51.013	Ulcerative (chronic) pancolitis with fistula
K51.014	Ulcerative (chronic) pancolitis with abscess

ICD-10 CM	ICD-10 DX Description
K51.018	Ulcerative (chronic) pancolitis with other complication
K51.019	Ulcerative (chronic) pancolitis with unspecified complications
K51.20	Ulcerative (chronic) proctitis without complications
K51.211	Ulcerative (chronic) proctitis with rectal bleeding
K51.212	Ulcerative (chronic) proctitis with intestinal obstruction
K51.213	Ulcerative (chronic) proctitis with fistula
K51.214	Ulcerative (chronic) proctitis with abscess
K51.218	Ulcerative (chronic) proctitis with other complication
K51.219	Ulcerative (chronic) proctitis with unspecified complications
K51.30	Ulcerative (chronic) rectosigmoiditis without complications
K51.311	Ulcerative (chronic) rectosigmoiditis with rectal bleeding
K51.312	Ulcerative (chronic) rectosigmoiditis with intestinal obstruction
K51.313	Ulcerative (chronic) rectosigmoiditis with fistula
K51.314	Ulcerative (chronic) rectosigmoiditis with abscess
K51.318	Ulcerative (chronic) rectosigmoiditis with other complication
K51.319	Ulcerative (chronic) rectosigmoiditis with unspecified complications
K51.40	Inflammatory polyps of colon without complications
K51.411	Inflammatory polyps of colon with rectal bleeding
K51.412	Inflammatory polyps of colon with intestinal obstruction
K51.413	Inflammatory polyps of colon with fistula
K51.414	Inflammatory polyps of colon with abscess
K51.418	Inflammatory polyps of colon with other complication
K51.419	Inflammatory polyps of colon with unspecified complications
K51.50	Left sided colitis without complications
K51.511	Left sided colitis with rectal bleeding
K51.512	Left sided colitis with intestinal obstruction
K51.513	Left sided colitis with fistula
K51.514	Left sided colitis with abscess
K51.518	Left sided colitis with other complication
K51.519	Left sided colitis with unspecified complications
K51.80	Other ulcerative colitis without complications
K51.811	Other ulcerative colitis with rectal bleeding
K51.812	Other ulcerative colitis with intestinal obstruction
K51.813	Other ulcerative colitis with fistula
K51.814	Other ulcerative colitis with abscess
K51.818	Other ulcerative colitis with other complication
K51.819	Other ulcerative colitis with unspecified complications
K51.90	Ulcerative colitis, unspecified, without complications
K51.911	Ulcerative colitis, unspecified with rectal bleeding
K51.912	Ulcerative colitis, unspecified with intestinal obstruction
K51.913	Ulcerative colitis, unspecified with fistula
K51.914	Ulcerative colitis, unspecified with abscess
K51.918	Ulcerative colitis, unspecified with other complication
K51.919	Ulcerative colitis, unspecified with unspecified complications
K52.1	Toxic gastroenteritis and colitis
K52.89	Other specified noninfective gastroenteritis and colitis
K52.9	Noninfective gastroenteritis and colitis, unspecified
K57.20	Diverticulitis of large intestine with perforation and abscess without bleeding

ICD-10 CM	ICD-10 DX Description
K57.21	Diverticulitis of large intestine with perforation and abscess with bleeding
K57.30	Diverticulosis of large intestine without perforation or abscess without bleeding
K57.31	Diverticulosis of large intestine without perforation or abscess with bleeding
K57.32	Diverticulitis of large intestine without perforation or abscess without bleeding
K57.33	Diverticulitis of large intestine without perforation or abscess with bleeding
K57.40	Diverticulitis of both small and large intestine with perforation and abscess without bleeding
K57.41	Diverticulitis of both small and large intestine with perforation and abscess with bleeding
K57.50	Diverticulosis of both small and large intestine without perforation or abscess without bleeding
K57.51	Diverticulosis of both small and large intestine without perforation or abscess with bleeding
K57.52	Diverticulitis of both small and large intestine without perforation or abscess without bleeding
K57.53	Diverticulitis of both small and large intestine without perforation or abscess with bleeding
K57.80	Diverticulitis of intestine, part unspecified, with perforation and abscess without bleeding
K57.81	Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding
K57.90	Diverticulosis of intestine, part unspecified, without perforation or abscess without bleeding
K57.91	Diverticulosis of intestine, part unspecified, without perforation or abscess with bleeding
K57.92	Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding
K57.93	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding
K62.0	Anal polyp
K62.1	Rectal polyp
K62.6	Ulcer of anus and rectum
K63.3	Ulcer of intestine
K63.5	Polyp of colon
Z12.10	Encounter for screening for malignant neoplasm of intestinal tract, unspecified
Z12.11	Encounter for screening for malignant neoplasm of colon
Z12.12	Encounter for screening for malignant neoplasm of rectum
Z15.060	Genetic susceptibility to colorectal cancer
Z15.068	Genetic susceptibility to other malignant neoplasm of digestive system
Z15.09	Genetic susceptibility to other malignant neoplasm
Z80.0	Family history of malignant neoplasm of digestive organs
Z83.710	Family history of adenomatous and serrated polyps
Z83.711	Family history of hyperplastic colon polyps
Z83.718	Family history of other colon polyps
Z83.719	Family history of colon polyps, unspecified
Z83.72	Family history of familial adenomatous polyposis
Z85.038	Personal history of other malignant neoplasm of large intestine
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
Z86.004	Personal history of in-situ neoplasm of other and unspecified digestive organs
Z86.0100	Personal history of colon polyps, unspecified
Z86.0101	Personal history of adenomatous and serrated colon polyps
Z86.0102	Personal history of hyperplastic colon polyps
Z86.0109	Personal history of other colon polyps
LIST 2: Applicable to 81528 (Cologuard), 0421U (Colosense™), 0464U (Cologuard Plus™), 0537U(Shield™) and G0327 (Blood-based Biomarker Tests) -only 1 dx req	
	Add coverage for 74263 effective 1/1/2025 for patients not at high risk.
Z12.11	Encounter for screening for malignant neoplasm of colon
Z12.12	Encounter for screening for malignant neoplasm of rectum

NCD:	210.3
NCD Title:	Colorectal Cancer Screening Tests
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=

ICD-10	ICD-10 PCS Description
N/A	N/A
	CMS reserves the right to add or remove diagnosis codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy.

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	Effective 1/1/98, payment may be made for colorectal cancer screening for early detection of cancer. For screening colonoscopy services (1 type of service included in benefit) prior to 7/1/01, coverage was limited to high-risk individuals. Effective 7/1/01, screening colonoscopies are covered for individuals not at high-risk. **CWF** shall edit all colorectal screening claims for age & frequency, **CWF** will edit A/MAC claims for valid procedure codes (G0104, G0105, G0106, 81528, 82270, G0120, G0121, G0122, G0327, G0328, and 0464U) and for valid TOBs. Add coverage for Cologuard Plus (0464U) effective 10/3/24. End date G0106, G0120, and G0122 effective 12/31/24. Add coverage for screening CT colonography (74263) effective 1/1/25. Add coverage for ShieldTM (0537U) effective 4/1/25 (FDA approval 7/26/24) Add coverage for ColoSense (0421U) effective 6/8/26	G0104 G0105 G0121 G0327 G0328 74263 81528 82270 0421U 0464U 0537U	varies by CPT/HCPCS	varies by CPT/ HCPCS	varies by CPT/ HCPCS	N/A	N/A	varies by rule see below	varies by rule see below	varies by rule see below
Part A	**CRC Screening:** **CWF/ (RC 59099/59100) & A/MACs:** Effective 1/1/2023, allow the following CRC screening tests for **ages 45 years and older:** -Screening Fecal-Occult Blood Tests (FOBT) (HCPCS codes G0328 and 82270) -Screening Flexible Sigmoidoscopies (HCPCS code G0104) -Screening Barium Enema (HCPCS codes G0106 and G0120)- End date G0106 and G0120 effective 12/31/24. -Screening CT colonography (CPT 74263) effective 1/1/25 **CWF/ FISS & A/MACs:** NOTE: Also refer to Pub 100-02, Benefit Policy Manual (BPM), chapter 15 section 280.2 Pub 100-03, NCD Manual, chapter 1, part 4, section 210.3 and Pub 100-04, Claims Processing Manual (CPM), Chapter 18 section 60. **A/MACs** shall not search for or adjust claims for colorectal cancer CRC screening tests that have been paid prior to April 3, 2023. However, contractors shall adjust claims brought to their attention.	G0104 G0328 82270 -------- 74263	N/A	N/A	N/A	N/A	N/A	18.29 ------ 15.4	6	N129

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**CRC Screening:** **CWF & A/MACs**: Effective for claims with dates of service on or after 1/1/2023, contractors shall be aware that CRC screening tests include a follow-on Screening Colonoscopy (HCPCS codes G0105 and G0121) after a Medicare covered non-invasive CRC screening test returns a positive result. Non-invasive CRC screening tests include: - Screening Immunoassay-based Fecal Occult Blood Test (iFOBT) (G0328) - Screening Guaiac-based Fecal Occult Blood Test (gFOBT) (82270) - Screening Blood-based Biomarker Test(G0327) - Screening The Cologuard™ – Multi-target Stool DNA (sDNA) Test (81528) - Cologuard Plus (0464U) effective 10/3/24 - Shield™ (0537U) effective 4/1/25 (FDA approval 7/26/24) -Add coverage for ColoSense (0421U) effective 6/8/26 - All FDA market authorized non-invasive biomarker tests that meet the coverage criteria specified in NCD 210.3 (effective 06/08/2026) Contractors shall also be aware that frequency limitations for Screening Colonoscopy shall not apply when the screening colonoscopy follows a positive result from a non-invasive screening test described above. **Note**: For additional claims processing information, refer to Pub 100-04, CPM, chapter 18, section 60.	G0105 G0121 ------ 81528 82270 G0327 G0328 0421U 0464U 0537U	no frequency limitations when the screening colonoscopy follows a positive result from a non invasive test	N/A	N/A	N/A	N/A	N/A	N/A	N/A

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**CRC Screening:** **CWF & A/MACs:** Effective 1/1/2023, contractors shall allow a follow-on screening colonoscopy (HCPCS code G0105 and G0121) after a Medicare covered CRC non-invasive test (HCPCS code G0328, 81528, 82270) returns a positive result. Add 0464U to non-invasive screening effective 10/3/24. Add 0537U to non-invasive CRC screening effective 4/1/25 (FDA approval 7/26/24). Add coverage for ColoSense (0421U) effective 6/8/26. - All FDA market authorized non-invasive biomarker tests that meet the coverage criteria specified in NCD 210.3 (effective -06/08/2026). **NOTE**: A -KX modifier shall be attached to a screening colonoscopy code to indicate such service was performed as a follow-on screening after a positive result from a non-invasive screening test. **A/MACs** shall return to provider claims for a follow-on screening colonoscopy after a Medicare covered non-invasive screening test returns a positive result when the KX modifier is not attached to the follow-on screening colonoscopy code. **CWF**: Effective for claims with dates of service on and after January 1, 2023, contractors shall not apply frequency limitations to CRC screening colonoscopy (HCPCS codes G0105 and G0121) that follows a positive result from a non-invasive CRC screening test (HCPCS code G0328, 81528, 82270, 0464U, 0537U) as identified by the KX modifier and described above. **A/MACs** shall not search for or adjust claims for CRC screening colonoscopies, described above, that have been paid prior to April 3, 2023. However, contractors shall adjust claims brought to their attention.	G0105 G0121 ------ 81528 82270 G0328 0421U 0464U 0537U	N/A	N/A	N/A	KX	N/A	N/A	N/A	N/A
Part A	**CRC Screening**: **A/MACs** shall engage in user acceptance testing when the code is delivered.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Part A	**FOBTs (immunoassay and guaiac types):** **FISS & A/MACs:** Shall allow FOBT 82270 or G0328 (as an alternative to 82270) **once per 12 months**; i.e., at least 11 months have passed following month in which last covered screening FOBT was performed. Effective 1/1/04, payment may be made for immunoassay-based FOBT, G0328, as an alternative to guaiac-based FOBT, 82270*. Medicare will pay for only one covered FOBT per year, either 82270* or G0328, but not both.	82270 G0328	1 x 12 months	13X 14X* (*only applicable for non-patient lab specimens) 22X 23X 83X 85X	030X	N/A	N/A	18.14 18.16	119 ---------- 119	M90 ---------- N386

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**CRC screening flexible sigmoidoscopy:** **A/MACs:** Shall allow G0104 when performed by doctor of medicine/osteopathy, or by PA, NP, or CNS (as defined in §1861(aa)(5) & in CFR 42 CFR 410.74, 410.75, 410.76) at frequency of 1 **every 48 months** (i.e., at least 47 months have passed following month in which last covered screening flexible sigmoidoscopy was done) unless beneficiary does not meet criteria for high-risk (refer to §60.3) and he/she has had screening colonoscopy, G0121, within preceding 10 years. If screening colonoscopy within preceding 10 years, then he/she can have screening flexible sigmoidoscopy only after at least 119 months have passed following month that he/she received screening colonoscopy, G0121.	G0104	1 x 48 months	12X 13X 22X 23X 83X 85X*	*CAH Method II bill RC 096X 097X and/or 098X for PC & 075X (or other RC) for TC	N/A	N/A	18.14 18.16	119 -------- 119 -------- 97	M86 ---------- N386 ---------- M86
Part A	**Screening barium enema:** **FISS & A/MACs:** Shall allow G0106 at frequency of **one every 48 months,** i.e., at least 47 months have passed following month in which last screening barium enema or screening flexible sigmoidoscopy was performed. Screening barium enema requires written order from beneficiary's attending physician. **End date G0106 and related edits effective 12/31/24.**	n/a	1 per 48 months	12X 13X 22X 23X 85X*	*CAH Method II bill RC 096X, 097X, and/or 098X for PC & 075X (or other RC) for TC	N/A	N/A	18.14 18.16	119 ---------- 119 ---------- 97	M86 ---------- N386 ---------- M86
Part A	**High-risk CRC colonoscopy:** **A/MACs:** Shall allow screening colonoscopies, G0105 **with approved Dx** when performed by doctor of medicine/osteopathy at frequency of 1 **every 24 months** for **beneficiaries at high risk** (i.e., at least 23 months have passed following month in which last covered G0105 screening colonoscopy was performed). **NOTE**- There may be more instances of conditions, which may be coded and could be considered high-risk at A/MAC discretion. This edit shall be overrideable. Additional dx will be at MAC discretion. RCs 59099/59100.	G0105	1 x 24 months	12X 13X 22X 23X 83X 85X*	*CAH Method II bill RC 096X 097X and/or 098X for PC & 075X (or other RC) for TC	N/A	N/A	18.14 18.16	119 ---------- 97	M83 ----------M86
Part A	**High-risk CRC barium enema:** **A/MACs**: Shall allow G0120 as alternative to G0105 **with payable high-risk DX** once every 24 months i.e., at least 23 months have passed following month in which last screening barium enema or last screening colonoscopy was performed, must have written order from beneficiary's attending physician. **NOTE:** There may be more instances of conditions, which may be coded and could be considered high-risk at medical directors' discretion. This edit shall be overrideable. Additional dx at MAC discretion. RCs 59099/59100. **End date G0120 and related edits effective 12/31/24.**	N/A	1 x 24 months	12X 13X 22X 23X 85X*	*CAH Method II bill RC 096X 097X and/or 098X for PC and 075X (or other RC) for TC	N/A	N/A	18.14 18.16	119 ---------- 97	M83 ---------- M86

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**CRC screening colonoscopy for non-high risk:** **FISS & A/MACs:** Shall allow **once every 10 years** i.e., at least 119 months have passed following month in which last covered G0121 screening colonoscopy was performed. If individual would otherwise qualify to have G0121 screening colonoscopy based on above (see §4180.2.D.1 and .2) but has had covered screening flexible sigmoidoscopy, G0104, then he/she may have G0121 screening colonoscopy only after at least 47 months have passed following month in which last covered G0104 flexible sigmoidoscopy was performed. **NOTE:** If during screening colonoscopy, a lesion/growth is detected which results in biopsy/removal of growth, appropriate dx procedure classified as colonoscopy with biopsy/removal should be billed and paid rather than G0121.	G0121	1 x 10 yrs for average risk patients; 1 x 2 years for high-risk patients	12X 13X 22X 23X 83X 85X*	*CAH Method II bill RC 096X 097X and/or 098X for PC & 075X (or other RC) for TC	N/A	N/A	18.14 18.16	119 --- 119 --- 97	M86 --- N386 --- M86
Part A	**CRC screening barium enema; Screening CT colonography:** **FISS & A/MACs:** Shall deny G0122 & 74263 as **non-covered** because they fail to meet benefit requirements. Beneficiary is liable for payment. Codes are not covered by Medicare. **End date G0122 effective 12/31/2024.** End date noncoverage of CPT 74263 CTC, screening effective 12/31/24. **Screening CTC 74263 is covered effective 1/1/25.**	N/A	N/A	12X 13X 22X 23X 85X*	*CAH Method II bill RC 096X 097X and/or 098X for PC & 075X (or other RC) for TC	N/A	N/A	16.10	49	N429
Part A	**Screening CT colonography:** **FISS & A/MACs:** Screening CT colonography 74263 is covered effective 1/1/25. CTC is limited to the following: **Not at High-Risk:** In the case of an individual age 45 or over who is not at high-risk of colorectal cancer, payment may be made for a screening CTC performed after at least 59 months have passed following the month in which the last screening CTC or 47 months have passed following the month in which the last flexible sigmoidoscopy or screening colonoscopy was performed. **High-Risk Patients:** In the case of an individual for colorectal cancer, payment may be made for a screening CTC performed after at least 23 months have passed following the month in which the last screening CTC or the last screening colonoscopy was performed. **NOTE:** Deductible and coinsurance are waived for screening CTC 74263 effective 1/1/25.	74263	different frequencies for not at high-risk and high-risk	12X 13X 22X 23X 85X*	*CAH Method II bill RC 096X 097X and/or 098X for PC & 075X (or other RC) for TC	N/A	N/A	15.6	119	N640

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**Non-invasive biomarker tests:** **FISS, A/MACs,** CWF shall allow following tests for approved dx 1 every 3 years for asymptomatic, average-risk beneficiaries aged 45 through 85 years: - Effective 10/9/14, shall allow Cologuard ™ test G0464 (CPT 81528 eff. 1/1/2016) - Effective 1/19/21, allow Blood-Based Biomarker tests using generic G0327 unless a more specific code becomes available (G0327 effective 7/1/21) - Effective 10/3/24, Cologuard Plus (0464U) is covered for colorectal screening. - Effective 7/26/24, Shield™ (0537U) is covered for colorectal screening (code effective 4/1/25). -Add coverage for ColoSense (0421U) effective 6/8/26 -- All FDA market authorized non-invasive biomarker tests that meet the coverage criteria specified in NCD 210.3 (effective -06/08/2026). Only one diagnosis- Z12.11 OR Z12.12 is required on the claim. NOTE: Deductible and coinsurance are waived. **CWF:** NOTE: also see Pub 100-02 BPM Chapter 15 Section 280.2 and Pub 100-03, NCD Manual, Chapter 1 Section 210.3.	81528 G0327 0421U 0464U 0537U	1 x 3 yrs	N/A	N/A	N/A	N/A	15.19 15.20 21.25	119 ----------6 ---------- 167 ---------- 170	N386 ----------N129 ----------N386 ---------- N95
Part A	**Anesthesia services with CRC screening:** **FISS, A/MACs:** For colorectal cancer screening, effective 1/1/18, when anesthesia 00812 is performed in conjunction with screening colonoscopy G0105 or G0121, coinsurance and deductible will be waived for anesthesia 00812. When screening colonoscopy becomes dx colonoscopy, anesthesia 00811 should be submitted with only -PT modifier and only deductible will be waived.	00811 (dx) 00812 (sc)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	Effective 1/1/98, payment may be made for colorectal cancer screening for early detection of cancer. For screening colonoscopy services (one of the services included in benefit) prior to 7/1/01, coverage was limited to high-risk individuals. Effective 7/1/01, screening colonoscopies are covered for individuals not at high-risk. **CWF** shall edit all colorectal screening claims for age and frequency standards. Add coverage for Cologuard Plus (0464U) effective 10/3/24. End date G0106, G0120, and G0122 effective 12/31/24. Add coverage for screening CT colonography (74263) effective 1/1/25. Add coverage for ShieldTM (0537U) effective 4/1/25 (FDA approval 7/26/24). Add coverage for ColoSense (0421U) effective 6/8/26	G0104 G0105 74263 82270 G0121 G0328 0421U 0464U 0537U	varies by CPT/HCPCS	N/A	N/A	N/A	N/A	varies by rule see below	varies by rule see below	varies by rule see below

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part B	**CRC Screening:** **B/MACs and CWF:** Effective 1/1/2023, allow the following CRC screening tests for **ages 45 years and older**. -Screening Fecal-Occult Blood Tests (FOBT) (HCPCS codes G0328 and 82270) -Screening Flexible Sigmoidoscopies (HCPCS code G0104) -Screening Barium Enema (HCPCS codes G0106 and G0120)- End date G0106 and G0120 effective 12/31/24. -Screening CTC (CPT 74263) effective 1/1/25 **B/MACs and CWF:** **NOTE**: Also refer to Pub 100-02, BPM, chapter 15 section 280.2 Pub 100-03, NCD Manual, chapter 1, part 4, section 210.3 and Pub 100-04, CPM, Chapter 18 section 60. **B/MACs** shall not search for or adjust claims for colorectal cancer CRC screening tests that have been paid prior to April 3, 2023. However, contractors shall adjust claims brought to their attention.	G0104 G0328 82270 --------- 74263	N/A	N/A	N/A	N/A	N/A	18.29 ------15.4	6	N129
Part B	**CRC Screening:** **CWF & B/MACs**: Effective for claims with dates of service on or after 1/1/2023, contractors shall be aware that CRC screening tests include a follow-on Screening Colonoscopy (HCPCS codes G0105 and G0121) after a Medicare covered non-invasive CRC screening test returns a positive result. Non-invasive CRC screening tests include: - Screening Immunoassay-based Fecal Occult Blood Test (iFOBT) (G0328) - Screening Guaiac-based Fecal Occult Blood Test (gFOBT) (82270) - Screening Blood-based Biomarker Test(G0327) - Screening The Cologuard™ – Multi-target Stool DNA (sDNA) Test (81528) - Cologuard Plus (0464U) effective 10/3/24 - Shield™ (0537U) effective 4/1/25 (FDA approval 7/26/24) -Add coverage for ColoSense (0421U) effective 6/8/26 -- All FDA market authorized non-invasive biomarker tests that meet the coverage criteria specified in NCD 210.3 (effective -06/08/2026). Contractors shall also be aware that frequency limitations for Screening Colonoscopy shall not apply when the screening colonoscopy follows a positive result from a non-invasive screening test described above. **Note**: For additional claims processing information, refer to Pub 100-04, CPM, chapter 18, section 60.	G0105 G0121 ------ 81528 82270 G0327 G0328 0421U 0464U 0537U	no frequency limitations when the screening colonoscopy follows a positive result from a non-invasive test.	N/A	N/A	N/A	N/A	N/A	N/A	N/A

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part B	**CRC Screening:** **CWF & B/MACs** shall allow a follow-on screening colonoscopy (HCPCS code G0105 and G0121) after a Medicare covered CRC non-invasive test (HCPCS code G0328, 81528, or 82270) returns a positive result. Add 0464U to non-invasive CRC screening effective 10/3/24. Add 0537U to non-invasive CRC screening effective 4/1/25 (FDA approval 7/26/24). Add coverage for ColoSense (0421U) effective 6/8/26 - All FDA market authorized non-invasive biomarker tests that meet the coverage criteria specified in NCD 210.3 (effective -06/08/2026). **NOTE**: A -KX modifier shall be attached to a screening colonoscopy code to indicate such service was performed as a follow-on screening after a positive result from a stool-based test. **B/MACs** shall return as unprocessable claims for a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based test returns a positive result, when the -KX modifier is not attached to the follow-on screening colonoscopy code. **CWF**: Effective for claims with dates of service on and after January 1, 2023, contractors shall not apply frequency limitations to CRC screening colonoscopy (HCPCS codes G0105 and G0121) that follows a positive result from a non-invasive CRC screening test (HCPCS code G0328, 81528, 82270, 0464U, 0537U) as identified by the -KX modifier and described above. **B/MACs** shall not search for or adjust claims for CRC screening colonoscopies, that have been paid prior to April 3, 2023. However, contractors shall adjust claims brought to their attention.	G0105 G0121 ------ 81528 82270 G0328 0421U 0464U 0537U	N/A	N/A	N/A	KX	N/A	N/A	16	N822/N823 Group code CO
Part B	**CRC Screening**: **B/MACs** shall engage in user acceptance testing when the code is delivered.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Part B	**FOBTs (immunoassay and guaiac types):** **B/MACs:** Shall allow FOBT 82270 or G0328 (as an alternative to 82270) 1 x **12 months**; i.e., at least 11 months have passed following month in which last covered screening FOBT was performed.	82270 G0328	1 x 12 months	N/A	N/A	N/A	N/A	18.14 18.16	119 ---------- 119	M90 ---------- N386
Part B	**CRC screening flexible sigmoidoscopy:** **B/MACs:** Shall allow G0104 when performed by doctor of medicine/osteopathy, or by PA, NP, or CNS (as defined in §1861(aa)(5) & CFR 42 CFR 410.74, 410.75, 410.76) at frequency of 1 x **48 months** (i.e., at least 47 months have passed following month in which last covered screening flexible sigmoidoscopy was done) unless beneficiary does not meet criteria for high-risk (refer to §60.3) and he/she has had a screening colonoscopy (HCPCS G0121) within preceding 10 years. If screening colonoscopy within preceding 10 years, then he/she can have screening flexible sigmoidoscopy only after at least 119 months have passed following month that he/she received screening colonoscopy, G0121.	G0104	1 x 48 months	N/A	N/A	N/A	N/A	18.14 18.16	119 ---------- 119 ---------- 97	M86 ---------- N386 ---------- M86

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part B	**Screening barium enema:** **B/MACs:** Shall allow G0106 at the frequency of **once every 48 months** i.e. at least 47 months have passed following month in which last screening barium enema or screening flexible sigmoidoscopy was performed. Screening barium enema requires written order from beneficiary's attending physician. **End date G0106 effective 12/31/24.**	N/A	1 x 48 months	N/A	N/A	N/A	N/A	18.14 18.16	119 --- 119 --- 97	M86 --- N386 --- M86
Part B	**High-risk CRC colonoscopy:** **MCS (025L) & B/MACs:** Shall allow G0105 with **payable high risk DX** 1 x 24 months i.e., at least 23 months have passed following month in which last screening barium enema or last screening colonoscopy was performed, when performed by doctor of medicine/osteopathy. MCS audit 025L **NOTE**- There may be additional dx considered high-risk at B/MAC discretion so this edit shall be overrideable.	G0105	1 x 24 months	N/A	N/A	N/A	N/A	18.14 18.16	119 --- 97	M83 --- M86
Part B	**High-risk CRC barium enema:** **MCS & B/MACs:** Shall allow G0120 as an alternative to G0105 with **payable high risk DX** 1 every 24 months i.e., at least 23 months have passed following month in which last screening barium enema or last screening colonoscopy was performed, must have written order from beneficiary's attending physician. MCS audit 025L **NOTE**- There may be additional dx considered high risk at B/MAC discretion so this edit shall be overrideable. End date G0120 effective 12/31/24.	N/A	1 x 24 months	N/A	N/A	N/A	N/A	18.14 18.16	119 --- 97	M83 ---M86
Part B	**CRC screening colonoscopy for non-high risk:** **B/MACs:** Shall allow CPT/HCPCS 1 x **10 years** i.e., at least 119 months have passed following month in which last covered G0121 screening colonoscopy was performed. If individual would otherwise qualify to have covered G0121 screening colonoscopy based on above (see §4180.2.D.1 and .2) but had a covered screening flexible sigmoidoscopy, G0104, then he/she may have G0121 screening colonoscopy only after at least 47 months have passed following month in which last covered G0104 flexible sigmoidoscopy was performed. **NOTE:** If during screening colonoscopy, a lesion/growth is detected which results in biopsy/removal of growth, appropriate dx procedure classified as colonoscopy with biopsy/removal should be billed and paid rather than G0121.	G0121	1 x 10 yrs for average risk patients; 1 x 2 years for high risk patients	N/A	N/A	N/A	N/A	18.14 18.16	119 --- 119 --- 97	M86 --- N386 --- M86
Part B	**CRC screening barium enema; Screening CT colonography:** **B/MACs:** Shall deny G0122 and 74263 as **non-covered** because they fail to meet benefit requirements. Beneficiary is liable for payment. Code is not covered by Medicare. **End date G0122 effective 12/31/24.** End date noncoverage of CPT 74263 CTC screening effective 12/31/24. **Screening CTC 74263 is covered effective 1/1/25.**	74263	N/A	N/A	N/A	N/A	N/A	16.10	49	N429

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part B	**Screening CT colonography:** **B/MACs:** Screening CTC 74263 is covered effective 1/1/25. CTC be limited to the following: **Not at High Risk:** In the case of an individual age 45 or over who is not at high-risk of colorectal cancer, payment may be made for a screening CTC performed after at least 59 months have passed following the month in which the last screening CTC or 47 months have passed following the month in which the last flexible sigmoidoscopy or screening colonoscopy was performed. **High-Risk Patients:** In the case of an individual for colorectal cancer, payment may be made for a screening CTC performed after at least 23 months have passed following the month in which the last screening CTC or the last screening colonoscopy was performed. **NOTE**: Deductible and coinsurance are waived for screening CTC 74263 effective 1/1/25.	74263	different frequencies for not at high-risk and high risk	N/A	N/A	N/A	N/A	15.6	119	N640
Part B	**Non-invasive biomarker tests:** **MCS, B/MACs, CWF** shall allow following tests for approved dx 1 every 3 years for asymptomatic, average-risk beneficiaries aged 45 through 85 years: - Effective 10/9/14, shall allow Cologuard TM test G0464 (CPT 81528 eff. 1/1/2016), and, - Effective 1/19/21, allow Blood-Based Biomarker tests using generic G0327 unless a more specific code becomes available (G0327 effective 7/1/21) - Effective 10/3/24 , Cologuard Plus (0464U) is covered for colorectal screening. - Effective 7/26/24, ShieldTM (0537U) is covered for colorectal screening (code effective 4/1/25). -Add coverage for ColoSense (0421U) effective 6/8/26 - All FDA market authorized non-invasive biomarker tests that meet the coverage criteria specified in NCD 210.3 (effective -06/08/2026). Only one diagnosis- Z12.11 OR Z12.12 is required on the claim. NOTE: Deductible and coinsurance are waived.	81528 G0327 0421U 0464U 0537U	1 x 3 yrs	13X 14X 85X	N/A	N/A	N/A	15.19 15.20 21.25	119 ----------6 ---------- 167 ---------- 170	N386 ----------N129 ----------N386 ---------- N95
Part B	**Anesthesia services with CRC screening:** **B/MACs:** For colorectal cancer screening, effective 1/1/18, when anesthesia 00812 is performed in conjunction with screening colonoscopy G0105 or G0121, coinsurance and deductible will be waived for anesthesia 00812. When screening colonoscopy becomes dx colonoscopy, anesthesia 00811 should be submitted with only -PT modifier and only deductible will be waived.	00811 (dx) 00812 (sc)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Date	Revision History
	CR8691: Clarify dx code restrictions apply to high-risk colorectal screening codes. Update CARC/RARC to comply with CORE. Add to dx tab: "Partial List of ICD-9-CM Codes Indicating High-Risk: Only applicable to G0105 and G0120 (high risk colorectal screening)".

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
	CR9252: Add new coverage for G0464 in Rule and dx tab. Add contractor discretion for G0105, G0120 in rows 13/14 & 24/25. Clarify FISS RC 59099/59100 shall be overridable per First Coast. Clarify all editing for NCD210.3 relative to new policy for stool DNA screening being performed in CR9115. Remove FISS, MCS from rows: 11, 20, 22, 23, 24, 25, 26. Add MCS to rows 24, 25 at their request to correspond to audit 025L. Add CWF to lines 17, 28 per MCS. Add additional dx codes per CMS MO and Z86.010 per NGS. Delete codes based on suggestion from JE MAC.									
	CR9540: Replace HCPCS G0464 with CPT 81528 as covered effective for claims with DOS on and after 1/1/16 in all related edits. Remove redundant columns on dx tab. Revise FISS RC31853, MCS edit 067L verbiage from 'AND' to 'OR' - ICD-10 Z12.12 OR ICD-10 Z12.11 effective 10/1/15 (ICD-9 V76.41 OR V76.51 effective 10/9/14).									
	CR9631: Replace 43 valid ICD-10 dx codes, 11 ICD-9 dx codes that were inadvertently removed from CR9252. FISS RC 59099, 59100. **CR9861:** Add C49.A3, C49.A4, C49.A5 as 3 new approved 2017 ICD-10 dx codes effective 10/1/16. FISS RC 59099/59100, MCS 025L. **CR10473:** Add statement regarding CPT 00812 from CR8874. Follow Instructions in CR 10181. End-date CPT 00810 effective 12/31/2017. Add CPT 00812 effective 1/1/2018. Remove ICD-9 dx codes from spreadsheet.									
	CR11491: Add ICD-10 dx Z86.004 effective 10/1/19. End- date ICD-10 dx C18.9, D12.6 effective 9/30/19. Add CPT 74263 as non-covered for Part B omitted in error. Non-covered status per OCE. (FISS 59099, 59100)									
	CR12280: Add G0327 effective 7/1/2021 lines 17 &29. Clarified CR9450 requirements "Only one diagnosis- Z12.11 OR Z12.12 is required on the claim." Update messaging in lines 17 & 29.									
	CR13017: Effective 1/1/2023, reduce the minimum age requirement for specified CRC screening tests from 50 to 45 years of age. Add a new rule that CRC screening tests include a follow-on screening colonoscopy after a positive result from a stool-based CRC screening test (the follow-on colonoscopy would no longer be diagnostic in this scenario). The follow-on screening colonoscopy is identified by the -KX modifier and frequency limitations would not apply under this rule.									
	CR13391: End date ICD-10 dx Z83.71 effective 9/30/2023. Add ICD-10 dx Z83.710, Z83.711, Z83.718, Z83.719 effective 10/1/2023. FISS 59099/59100 025L									
	CR13828: End date ICD-10 dx Z86.010 effective 9/30/2024. Add ICD-10 dx Z83.72, Z86.0100, Z86.0101, Z86.0102, and Z86.0109 effective 10/1/2024. (FISS RC 59099/59100, MCS 025L)									
	CR13939: End-date G0106, G0120, G0122 effective 12/31/24. Add coverage for screening CT colonography CPT 74263 effective 1/1/25. Remove stool-based language from policy to allow for all non-invasive CRC screening tests. Add Cologuard Plus™ 0464U effective FDA approval 10/3/24. Add 0537U for colorectal cancer screening Shield™ code effective 4/1/25, FDA approval 7/26/24. Reinstate K codes inadvertently removed from ICD-10 dx tab in CRs 13391 and 13828 effective 10/1/15. RARC M82 replaced with new RARC N906 to allow for age 45 and older. MSN 18.14 revised to include 60 months.									
	CR14197: Add ICD-10 CM code Z15.060 and Z15.068 to list 1 effective 10/1/2025. Revise descriptor for ICD-10 CM code Z83.718 in list 1 effective 10/1/2025. In accordance with CR 14031: MSN, CARC and RARC messages revised on rows 9, 20, 25 and 36 to align with IOM 100-04 Chapter 18 Section 60.									

NCD:	210.3
Title:	Colorectal Cancer Screening Tests (CR5127, CR8109, CR8691, CR9115, CR9252, CR9540, CR9631, CR9861, CR10473, CR11491, CR12280, CR13017, CR13391, CR13828, CR13939, CR14197, **CR14581**)
IOM:	www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&CoverageSelection=National&bc=gAAAACAAAAAA&=
CPM	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

Part A	Rule Description Part A	Proposed HCPCS/ CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A/B	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
	CR14581: Add (Colosense™) 0421U effective 6/8/26. All FDA market authorized non-invasive biomarker tests that meet the coverage criteria specified in NCD 210.3 (effective -06/08/2026).									