CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 196	**Date: October 17, 2014**
	Change Request 8881

SUBJECT: Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) and Screening Fecal-Occult Blood Tests (FOBT)

I. SUMMARY OF CHANGES: Effective for dates of service on and after January 27, 2014, contractors shall pay claims for Ultrasound screening for AAA and screening FOBTs, per the modified requirements in 42 CFR 410.19 and 410.37.

EFFECTIVE DATE: January 27, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 18, 2014

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/280.2.2/Coverage Criteria

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 obliged 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. 100-02	Transmittal: 196	Date: October 17, 2014	Change Request: 8881

SUBJECT: Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) and Screening Fecal-Occult Blood Tests (FOBT)

EFFECTIVE DATE: January 27, 2014
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I. GENERAL INFORMATION

A. Background: Medicare Part B coverage of screening FOBTs is covered for certain beneficiaries that meet eligibility requirements, including that the beneficiary receive a written order for a screening FOBT from his/her attending physician. As part of the CY 2014 Physician Fee Schedule rule, CMS revised 42 CFR 410.37(b), the Medicare Part B coverage requirements for Screening FOBT, to allow the beneficiary's attending physician assistant, nurse practitioner, or clinical nurse specialist to furnish written orders for screening FOBT.

B. Policy: Effective for dates of service on and after January 27, 2014, a screening FOBT is covered if a written order is furnished by the beneficiary's attending physician, physician assistant, nurse practitioner, or clinical nurse specialist, and meets other coverage criteria outlined in 42 CFR 410.37.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8881 - 02.1	Effective for dates of service on and after January 27, 2014, contractors shall pay claims for screening FOBT, if a written order for such test is furnished by the beneficiary's attending physician, physician assistant, or clinical nurse specialist, and meets other coverage criteria (See Pub. 100-02, chapter 15, section 280.2.2).	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8881 - 02.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

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

V. CONTACTS

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

VI. 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: 0

280.2.2 - Coverage Criteria

(Rev. 196, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

The following are the coverage criteria for these screenings:

A. Screening Fecal-Occult Blood Tests (FOBT) (Codes G0107 & G0328)

Effective for services furnished on or after January 1, 2004, one screening FOBT (code G0107 **or** G0328) is covered for beneficiaries who have attained age 50, 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 done). Screening FOBT means: (1) a guaiac-based test for peroxidase activity in which the beneficiary completes it by taking samples from two different sites of three consecutive stools **or**, (2) an immunoassay (or immunochemical) test for antibody activity in which the beneficiary completes the test by taking the appropriate number of samples according to the specific manufacturer's instructions. This expanded coverage is in accordance with revised regulations at 42 CFR 410.37(a)(2) that includes " other tests determined by the Secretary through a national coverage determination." This screening requires a written order from the beneficiary's attending physician *or for claims with dates of service on or after January 27, 2014, from the beneficiary's attending physician assistant, nurse practitioner, or clinical nurse specialist*. (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.)

NOTE: *For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107, is discontinued and replaced with CPT code 82270. For complete claims processing information refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 60.*

B. Screening Flexible Sigmoidoscopies (code G0104)

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

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

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

For services furnished on or after July 1, 2001

Once every 48 months as calculated above **unless** the beneficiary does not meet the criteria for high risk of developing colorectal cancer (refer to §280.2.3) **and** the beneficiary has had a screening colonoscopy (code G0121) within the preceding 10 years. If such a beneficiary has had a screening colonoscopy within the preceding 10 years, then he or she can have covered a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that he/she received the screening colonoscopy (code G0121).

NOTE: If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed and paid rather than code G0104.

C. Screening Colonoscopies for Beneficiaries at High Risk of Developing Colorectal Cancer (Code G0105)

The *A/B MAC (B)* must pay for screening colonoscopies (code G0105) when performed by a doctor of medicine or osteopathy at a frequency of once every 24 months for beneficiaries at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered G0105 screening colonoscopy was performed). Refer to §280.2.3 for the criteria to use in determining whether or not an individual is at high risk for developing colorectal cancer.

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

D. Screening Colonoscopies Performed on Individuals Not Meeting the Criteria for Being at High-Risk for Developing Colorectal Cancer (Code G0121)

Effective for services furnished on or after July 1, 2001, screening colonoscopies (code G0121) are covered when performed under the following conditions:

1. On individuals not meeting the criteria for being at high risk for developing colorectal cancer (refer to §280.2.3);

2. At a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered G0121 screening colonoscopy was performed); and

3. If the individual would otherwise qualify to have covered a G0121 screening colonoscopy based on the above (see §§280.2.2.D.1 and 2) **but** has had a covered screening flexible sigmoidoscopy (code G0104), then the individual may have a covered G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered G0104 flexible sigmoidoscopy was performed.

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

E. Screening Barium Enema Examinations (codes G0106 and G0120)

Screening barium enema examinations are covered as an alternative to either a screening sigmoidoscopy (code G0104) or a screening colonoscopy (code G0105) examination. The same frequency parameters for screening sigmoidoscopies and screening colonoscopies above apply.

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

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

G0120) as an alternative to a screening colonoscopy (code G0105) in January 2000. The count starts beginning February 2000. The beneficiary is eligible for another screening barium enema examination (code G0120) in January 2002.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, for the same individual. The screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.