

MEDICARE PART A BULLETIN

December 12, 1997

Hospital Medicare Bulletin H-84

TO: Hospital Medicare Providers
FROM: Provider Relations

SUBJECT: MEDICARE COVERAGE OF COLORECTAL CANCER SCREENING

ATTENTION MEDICARE BUSINESS OFFICE MANAGER: Please distribute to all appropriate health care facility personnel.

Section 4104 of the Balanced Budget Act (BBA) of 1997 provides for coverage of various colorectal screening examinations subject to certain coverage, frequency, and payment limitations. Effective for services furnished on or after January 1, 1998, Medicare will cover colorectal cancer screening test/procedures for the early detection of colorectal cancer. Coverage of the colorectal cancer screening tests includes the following procedures furnished to an individual:

- ◆ Screening fecal-occult blood test;
- ◆ Screening flexible sigmoidoscopy;
- ◆ Screening colonoscopy, for high risk individuals; and
- ◆ Screening barium enema as an alternative to a screening flexible sigmoidoscopy or screening colonoscopy.

HCPCS CODING

The following new HCPCS codes have been established for these services:

- ❖ G0107 Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations;
- ❖ G0104 Colorectal cancer screening; flexible sigmoidoscopy;
- ❖ G0105 Colorectal cancer screening; colonoscopy on individual at high risk;
- ❖ G0106 Colorectal cancer screening; barium enema; as an alternative to G0104, screening sigmoidoscopy;
- ❖ G0120 Colorectal cancer screening; barium enema; as an alternative to G0105, screening colonoscopy;
- ❖ G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk (non-covered); and
- ❖ G0122 Colorectal cancer screening; barium enema (non-covered).

COVERAGE

The following are the coverage criteria for these new screenings:

- ➔ Screening fecal-occult blood tests (code G0107) are covered at a frequency of once every 12 months for beneficiaries who have attained age 50 (i.e., at least 11 months have passed, following the month in which the last covered screening fecal-occult blood test was done). Screening fecal-occult blood test means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. This screening requires a written order from the beneficiary's attending physician. [The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.]
 - ➔ Screening flexible sigmoidoscopies (code G0104) are covered at a frequency of once every 48 months for beneficiaries who have attained age 50 (i.e., at least 47 months have passed, following the month in which the last covered screening flexible sigmoidoscopy was done). 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. This screening must be performed by a doctor of medicine or osteopathy.
 - ➔ Screening colonoscopies (code G0105) are covered at a frequency of once every 24 months for beneficiaries at high risk for colorectal cancer (i.e., at least 23 months have passed, following the month in which the last covered screening colonoscopy was done). High risk for colorectal cancer means an individual with one or more of the following:
 - a close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyposis;
 - a family history of familial adenomatous polyposis;
 - a family history of hereditary nonpolyposis colorectal cancer;
 - a personal history of adenomatous polyps; or
 - a personal history of colorectal cancer; or
 - inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.
- 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. This screening must be performed by a doctor of medicine or osteopathy.
- ➔ Screening barium enema examinations (codes G0106 and G0120) are covered as an alternative to either a screening sigmoidoscopy (code G0104) or a screening colonoscopy (code G0105) examination. The same frequency parameters specified in the law for screening sigmoidoscopy and screening colonoscopy apply.

In the case of an individual age 50 or over, who is not at high risk of colorectal

cancer, payment may be made for a screening barium enema examination performed after at least 47 months have passed, following the month, in which the last screening barium enema or screening flexible sigmoidoscopy was performed.

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

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. 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.

→ Listed below are some examples of diagnoses that meet the high risk criteria for colorectal cancer. This is not an all inclusive list. There may be more instances of conditions which may be coded and could be at the medical directors' discretion.

ICD-9-CM CODES

Personal History:

10.05 Personal history of malignant neoplasm of large intestine

V1006 Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

Chronic Digestive Disease Condition:

555.0 Regional enteritis of small intestine

555.1 Regional enteritis of large intestine

555.2 Regional enteritis of small intestine with large intestine

555.9 Regional enteritis of unspecified site

556.0 Ulcerative (chronic) enterocolitis

556.1 Ulcerative (chronic) ileocolitis

556.2 Ulcerative (chronic) proctitis

556.3 Ulcerative (chronic) proctosigmoiditis

556.8 Other ulcerative colitis

556.9 Ulcerative colitis, unspecified (non-specific PDX on the MCE)

Inflammatory Bowel:

558.2 Toxic gastroenteritis and colitis

558.9 Other and unspecified non-infectious gastroenteritis and colitis

NON-COVERED SERVICES

Two non-covered HCPCS codes have been created to assist in reporting for the following:

- Code G0121 (colorectal cancer screening; colonoscopy on an individual not meeting criteria for high risk) should be used when this procedure is performed on a beneficiary who does NOT meet the criteria for high risk. This service will be denied as non-covered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.
- Code G0122 (colorectal cancer screening; barium enema) should be used when a screening barium enema is performed NOT as an alternative to either a screening colonoscopy (code G0105) or a screening flexible sigmoidoscopy (code G0104). This service will be denied as non-covered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

Reporting of these non-covered codes will also allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes.

FREQUENCY OF TESTING

To determine the 11, 23, and 47 month periods, begin counting with the month after the month in which a previous test/procedure was performed.

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

BILLING REQUIREMENTS

Hospitals will bill on Form HCFA-1450 (UB-92) claims format using type of bill codes 13x, 83x, or 85x. In addition, the hospital report revenue codes and HCPCS codes as follows:

<u>Screening Test/Procedure</u>	<u>Rev Code</u>	<u>HCPCS Code</u>
occult blood test	30X	G0107
barium enema	32X	G0106, G0120, G0122
flexible sigmoidoscopy	*	G0104
colonoscopy-high risk	*	G0105, G0121

*Report the appropriate revenue code used for the surgical procedure.

PAYMENT

Payment until January 1, 1999, for hospital outpatient departments will be as follows:

\$ Payment for screening fecal-occult blood test (code G0107) will be under the clinical diagnostic laboratory fee schedule using payment amount associated with code G0107;

\$ Payment for screening flexible sigmoidoscopy (code G0104) will be based on cost reimbursement; and

\$ Payment for screening colonoscopy (code G0105) will be subject to the ambulatory surgical center blended payment method and payment for screening barium enema (codes G0106 or G0102) will be subject to the radiology blended payment method.

Part B deductible and coinsurance will apply.

MEDICARE SUMMARY NOTICE (MSN) MESSAGES

If a claim for a screening fecal-occult blood test, a screening flexible sigmoidoscopy, or a barium enema is being denied because of the age of the beneficiary, the following message will be reflected on the MSN:

“This service is not covered for beneficiaries under 50 years of age.”

If the claim for a screening fecal-occult blood test, a screening colonoscopy, a screening flexible sigmoidoscopy, or a barium enema is being denied because the time period between the same test or procedure has not passed, the following message will be reflected on the MSN :

“Service is being denied because it has not been (12, 24, 48) months since your last (test/procedure) of this kind.”

If the claim is being denied for a screening colonoscopy or a barium enema because the beneficiary is not at a high risk, the following message will be reflected on the MSN:

“Medicare only covers this procedure for beneficiaries considered to be at a high risk for colorectal cancer.”

If the claim is being denied because payment has already been made for a screening flexible sigmoidoscopy (code G0104), screening colonoscopy (code G0105), or a screening barium enema (code G0106 or G0120), the following message will be reflected on the MSN:

“This service is denied because payment has already been made for a similar procedure within a set time frame.”

NOTE: The above message may also appear on the MSN when a certain screening procedure is performed as an alternative to another screening procedure. For example: If a claim has received payment on code G0120 and the incoming claim is submitted for code G0105, within 24 months, the incoming claim will be denied.

If the claim is being denied for non-covered screening procedure codes G0121 or G0122 the following message will appear on the MSN:

“Medicare does not pay for this item or service.”

REMITTANCE ADVICE NOTICES

If the claim for a screening fecal-occult blood test, a screening flexible sigmoidoscopy, or a screening barium enema is being denied because the patient is under 50 years of age, the existing American National Standard Institute (ANSI) X12-835 claim adjustment reason code 6 will be reflected on the Remittance Advice (RA) “the procedure code is inconsistent with the patient’s age,” along with remark code M82 “Service is not covered when beneficiary is under age 50.”

If the claim for a screening fecal-occult blood test, a screening colonoscopy, a screening flexible sigmoidoscopy, or a screening barium enema is being denied because the time period between the test/procedure has not passed, then ANSI X12-835 claim adjustment reason code 119 will be reflected on the RA “Benefit maximum for this time period has been reached”.

If the claim is being denied for a screening colonoscopy or a screening barium enema because the beneficiary is not at a high risk, then ANSI X12-835 claim adjustment reason code 46 will be reflected on the RA, “This procedure is not covered” along with remark code M83 “Service is not covered unless the beneficiary is classified as a high risk.”

If the service is being denied because payment has already been made for a similar procedure within the set time frame, then ANSI X12-835 claim adjustment reason code 18 will be reflected on the RA, “Duplicate claim/service” along with remark code M86 “This service is denied because payment has already been made for a similar procedure within a set time frame.”

AMBULATORY SURGICAL CENTER FACILITY FEE

CPT code 45378, which is used to code a diagnostic colonoscopy, is on the list of procedures approved by Medicare for payment of an ambulatory surgical center (ASC) facility fee under §1833(I) of the Act. CPT code 45378 is currently assigned to ASC payment group two (2). HCFA proposes to add the new code G0105, colorectal cancer screening; colonoscopy on individual at high risk, to the ASC list. HCFA believes that the facility services are the same whether the procedure is a screening or a diagnostic colonoscopy, and HCFA is, therefore, assigning code G0105 to payment group two (2), which is the same payment rate assigned to CPT code 45378. If during the course of the screening colonoscopy performed at an ASC, 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 rather than code G0105.

Questions regarding this bulletin may be addressed to the Medicare Customer Service Department by calling (904) 355-8899.