

Clinical Guidelines

CMS MEDICAL LEARNING NETWORK

Colorectal Cancer: Preventable, Treatable, and Beatable

Medicare Coverage and Billing for Colorectal Cancer Screening

Provider Types Affected

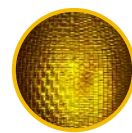
Physicians, nurse practitioners, physician assistants, clinical nurse specialists, outpatient hospital departments, and community surgical centers.

Provider Action Needed



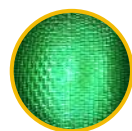
STOP — Impact to You

CMS would like to remind providers to encourage their eligible Medicare patients ages 50 and older to get screened for colorectal cancer. In addition, you should review Medicare coverage and billing processes for colorectal cancer screening.



CAUTION — What You Need to Know

Medicare has covered colorectal cancer screening since 1998, but the benefit is underused. Claims data from 1998-2002 indicate that less than half of Medicare beneficiaries had any screening test during this 5-year period, and less than one-third were tested according to recommended intervals.



GO — What You Need to Do

Encourage your patients to be screened, appropriately bill Medicare for the screening test you provide, and follow up with patients, as needed.

Background

Colorectal cancer is the second leading cause of cancer death in the United States and the third most common type of cancer. In 2005, colorectal cancer was expected to account for 56,290 deaths and 145,290 new cases. Colorectal cancer primarily affects men and women ages 50 and older, and risk increases with age. If detected early, colorectal cancer can be treated and cured.

In January 1998, Medicare began covering colorectal cancer screening. The data currently available (1998-2002) indicate that the colorectal cancer screening benefit is underused. Less than half of enrollees had any colorectal cancer test during the 5-year period and less than one-third were tested according to recommended intervals.

The US Preventive Services Task Force (USPSTF) evaluates the clinical merits of preventive measures, and strongly recommends (“A” rating) that clinicians screen men and women ages 50 and older for colorectal cancer. The choice of screening strategy should be based on patient preferences, medical contraindications, patient adherence, and resources for testing and follow-up. To read the full recommendation, go to the following link: www.ahrq.gov/clinic/uspstf/uspscolo.htm.

The Partnership for Prevention conducted a systematic assessment of the clinical preventive services recommended by the USPSTF to help decision-makers identify those services that provide the most value based on 2 criteria—burden of disease prevented and cost-effectiveness. Screening adults for colorectal cancer was among the services considered to be of the greatest value.

Colorectal Cancer Screening Methods

There are a variety of methods available for colorectal cancer screening, including fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, and screening barium enema. It is important that practitioners follow the practice guidelines for screening and follow-up.

Two studies published in January 2005 in the *Annals of Internal Medicine* suggest that the office-based, single-sample, screening fecal

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occult blood test is of limited value, and that many physicians are not following practice guidelines for screening and follow-up. Go to the following link for information on colorectal cancer detection and American Cancer Society screening recommendations and guidelines: www.cancer.org/docroot/CRI/content/CRI_2_6X_Colorectal_Cancer_Early_Detection_10.asp?sitearea=&level.

Coverage

Medicare covers the following colorectal cancer screening tests and procedures:

Fecal Occult Blood Test (FOBT)

Medicare covers one FOBT annually for beneficiaries 50 and older. A written order from the beneficiary's attending physician is required. Medicare will pay for an immunoassay-based FOBT as an alternative to the guaiac-based FOBT, but will pay for only 1 FOBT, not both, per year. Beneficiaries do not have to pay coinsurance for the FOBT, and don't have to meet the annual Medicare Part B deductible.

Screening Flexible Sigmoidoscopy

Medicare covers a screening flexible sigmoidoscopy once every 4 years for beneficiaries 50 and older. If a beneficiary had a screening colonoscopy in the previous 10 years, then the next screening flexible sigmoidoscopy would be covered only after 119 months have passed following the month in which the last screening colonoscopy was performed. A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist may perform a screening flexible sigmoidoscopy.

Screening Colonoscopy

Medicare coverage for a screening colonoscopy is based on beneficiary risk.

- For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers 1 screening colonoscopy every 10 years, but not within 47 months of a previous screening flexible sigmoidoscopy.
- For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers 1 screening colonoscopy every 2 years, regardless of age.

A screening colonoscopy must be ordered and provided by a doctor of medicine or osteopathy.

Screening Barium Enema

Medicare covers a screening barium enema as an alternative to a screening flexible sigmoidoscopy or a screening colonoscopy.

- For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers 1 screening barium enema every 4 years.
- For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers 1 screening barium enema every 2 years, regardless of age.

A screening barium enema must be ordered in writing and provided by a doctor of medicine or osteopathy once it is determined that it is the appropriate screening method for a beneficiary. A double contrast barium enema is preferable, but the physician may order a single contrast barium enema if it is more appropriate for the beneficiary.

The beneficiary is liable for paying 20% of the Medicare-approved amount (the coinsurance) for screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema after meeting the annual Medicare Part B deductible.

Screening Flexible Sigmoidoscopy or a Screening Colonoscopy: High-risk Beneficiaries

For a screening flexible sigmoidoscopy or a

screening colonoscopy performed in a hospital outpatient department, the beneficiary is liable for paying the Medicare-approved amount (the coinsurance) after meeting the annual Medicare Part B deductible.

Beneficiaries are considered to be at high risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- A personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

How to Bill Medicare

Table 1 shows the Healthcare Common Procedure Coding System (HCPCS) codes that should be used to bill for colorectal cancer screening.

If billing Medicare carriers, the appropriate HCPCS and corresponding diagnosis codes must be provided on Form CMS-1500 (or the HIPAA 837 Professional electronic claim record).

If billing Medicare intermediaries, the appropriate HCPCS, revenue, and corresponding diagnosis codes must be provided on Form CMS-1450 (or the HIPAA Institutional electronic claim record). Information on the type of bill and associated revenue code is also provided in the colorectal cancer screening chapter (page 82) of the *Guide to Preventive Services*. This guide is available at: on the CMS Web site at www.cms.hhs.gov/Medlearn-Products/downloads/PSGUID.pdf. Reimbursement information is also provided in this guide. MPM

Disclaimer

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Table 1.

Health Care Common Procedure Coding System Codes

| HCPCS Code | HCPCS Code Descriptor |
|------------|---|
| G0104 | Colon cancer screening; flexible sigmoidoscopy |
| G0105* | Colon cancer screening; colonoscopy on individual at high risk |
| G0106 | Colon cancer screening; barium enema as an alternative to G0104 |
| G0107 | Colon cancer screening; FOBT, 1-3 simultaneous determinations |
| G0120 | Colon cancer screening; barium enema as an alternative to G0105 |
| G0121 | Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk |
| G0122† | Colon cancer screening; barium enema (non-covered) |
| G0328 | Colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations |

* When billing for the "high risk" beneficiary, the screening diagnosis code on the claim must reflect at least 1 of the high risk conditions mentioned previously. Examples of diagnostic codes are in the colorectal cancer screening chapter (page 81) of the *Guide to Preventive Services*. This guide is available at www.cms.hhs.gov/MedlearnProducts/downloads/PSGUID.pdf on the CMS Web site.

† Code G0122 should be used when a screening barium enema is performed, not as an alternative to either to G0104 or G0105. This service is denied as non-covered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment. Reporting of this non-covered code will also allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes.