Article - Billing and Coding: Colorectal Cancer Screening – Medical Policy Article (A52378)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
National Government Services, Inc.	MAC - Part A	06101 - MAC A	J - 06	Illinois
National Government Services, Inc.	MAC - Part B	06102 - MAC B	J - 06	Illinois
National Government Services, Inc.	MAC - Part A	06201 - MAC A	J - 06	Minnesota
National Government Services, Inc.	MAC - Part B	06202 - MAC B	J - 06	Minnesota
National Government Services, Inc.	MAC - Part A	06301 - MAC A	J - 06	Wisconsin
National Government Services, Inc.	MAC - Part B	06302 - MAC B	J - 06	Wisconsin
National Government Services, Inc.	A and B and HHH MAC	13101 - MAC A	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13102 - MAC B	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13201 - MAC A	J - K	New York - Entire State
National Government Services, Inc.	A and B and HHH MAC	13202 - MAC B	J - K	New York - Downstate
National Government Services, Inc.	A and B and HHH MAC	13282 - MAC B	J - K	New York - Upstate
National Government Services, Inc.	A and B and HHH MAC	13292 - MAC B	J - K	New York - Queens
National Government Services, Inc.	A and B and HHH MAC	14111 - MAC A	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14112 - MAC B	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14211 - MAC A	J - K	Massachusetts
National Government Services,	A and B and HHH	14212 - MAC B	J - K	Massachusetts

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Inc.	MAC			
National Government Services, Inc.	A and B and HHH MAC	14311 - MAC A	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14312 - MAC B	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14411 - MAC A	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14412 - MAC B	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14511 - MAC A	J - K	Vermont
National Government Services, Inc.	A and B and HHH MAC	14512 - MAC B	J - K	Vermont

Article Information

General Information

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CMS National Coverage Policy

N/A

Article Guidance

Article Text

Abstract:

This article represents local instructions for CMS National Coverage Policy (CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Section 210.3). **All italicized text is quoted verbatim from CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 18, Sections 60-60.3 unless otherwise noted.**

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:

- *Fecal-occult blood test (FOBT), 1-3 simultaneous determinations (guaiac-based);*
- *Flexible sigmoidoscopy;*
- *Colonoscopy; and,*
- *Barium enema*

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:

- *Fecal-occult blood test, immunoassay, 1-3 simultaneous determinations*

Effective for claims with dates of service on or after October 9, 2014, payment may be made for colorectal cancer screening using the Cologuard™ multitarget stool DNA (sDNA) test:

- *G0464 (Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3).*

(See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60)

- *Blood-based biomarker test (effective for dates of service on or after January 19, 2021)*

*(*See CMS Publication 100-03,*National Coverage Determination (NCD)* 210.3 -Screening for Colorectal Cancer)

Indications and Limitations:

HCPCS 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, contractors or carriers 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, nurse practitioner, or clinical nurse specialist (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. 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* **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).*

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.* (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2)

HCPCS G0105 - Colorectal Cancer Screening; 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). (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2)

Characteristics of the High Risk Individual:

An individual at high risk for developing colorectal cancer has one or more of the following:

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

(See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.3)

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.* (CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2)

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. (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2(A)(1) for additional information.) (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2)

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

Screening barium enema examinations may be paid as an alternative to a screening sigmoidoscopy (HCPCS G0104). The same frequency parameters for screening sigmoidoscopies (see those codes above) apply.

In the case of an individual aged 50 or over, payment may be made for a screening barium enema examination (HCPCS 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. Start counts beginning February 1999. The beneficiary is eligible for another screening barium enema in January 2003.

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 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. (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2)

CPT 82270* HCPCS G0107* - Colorectal Cancer Screening; Fecal-Occult Blood Test, 1-3 Simultaneous Determinations

Effective for services furnished on or after January 1, 1998, screening FOBT [fecal-occult blood test] (CPT 82270) (HCPCS G0107*) 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. (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 82270 (HCPCS G0107*). Medicare will pay for only one covered FOBT per year, either CPT 82270* (HCPCS G0107*) or HCPCS G0328, but not both.*

***NOTE:** For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 is discontinued and replaced with CPT 82270. (*See CMS Publication

100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2)

HCPCS G0328 - Colorectal Cancer Screening; Immunoassay, Fecal-Occult Blood Test, 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 82270 (HCPCS G0107*) for beneficiaries who have attained age 50. Medicare will pay for a covered FOBT (either CPT 82270* (HCPCS G0107*) 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 dates of service on or after January 27, 2014, 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.)* (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2)

HCPCS G0120 - Colorectal Cancer Screening; Barium Enema; as an Alternative to HCPCS G0105, Screening Colonoscopy

Screening barium enema examinations may be paid as an alternative to a screening colonoscopy (HCPCS G0105) examination. The same frequency parameters for screening colonoscopies (see those codes above) apply.

In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination (HCPCS 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 colonoscopy barium enema examination (HCPCS G0120) as an alternative to a screening colonoscopy (HCPCS G0105) in January 2000. Start counts beginning February 2000. The beneficiary is eligible for another screening barium enema examination (HCPCS 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 colonoscopy, 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. (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2)

HCPCS G0121 - Colorectal 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 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 the individual 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* (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2)

HCPCS G0464 (Replaced with CPT 81528) - Multitarget Stool DNA (sDNA) Colorectal Cancer Screening Test - CologuardTM

Effective for dates of service on or after October 9, 2014, colorectal cancer screening using the CologuardTM multitarget sDNA test (G0464/81528) is covered once every 3 years for Medicare beneficiaries that meet all of the following criteria:

- *Ages 50 to 85 years,*
- *Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test 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 cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).*

See Pub. 100-03, *Medicare National Coverage Determinations Manual,* Chapter 1, Section 210.3, for complete coverage requirements.

(See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.2)

Frequency limits for colorectal screening examinations are determined by CMS national policy. Although fecal occult blood screening (HCPCS 82270/G0107 and G0328) is allowed annually, the frequency for all other examinations depends on whether the individual is or is not considered at high risk for colorectal cancer.

G0327 (Colorectal cancer screening; blood-based biomarker)

Effective for dates of service on or after January 19, 2021, a blood-based biomarker test is covered as an appropriate colorectal cancer screening test once every 3 years for Medicare beneficiaries when performed in a Clinical Laboratory Improvement Act (CLIA)-certified laboratory, when ordered by a treating physician and when all of the following requirements are met:

The patient is:

- *age 50-85 years, and,*

- *asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test 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 cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).*

The blood-based biomarker screening test must have all of the following:

- *Food and Drug Administration (FDA) market authorization with an indication for* colorectal cancer scree*ning; and,*

- *proven test performance characteristics for a blood-based screening test with both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in the detection o*f colorectal cancer c*ompared to the recognized standard (accepted as colonoscopy at this time), as minimal threshold levels, based on the pivotal studies included in the FDA.*

Coding Information:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines
An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 30, for complete instructions.

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 critical access hospital (CAH) has elected payment Method II for CAH patients, payment shall be consistent with payment methodologies currently in place … As such, CAHs that elect Method II payment [should] 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 contractor to document the incomplete procedure. (See CMS Publication 100-04, *Medicare*

Claims Processing Manual, Chapter 18, Section 60.2)

HCPCS 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 should be denied as noncovered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment. (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.5)

Effective for claims with dates of service on or after January 19, 2021, providers shall report at least ONE of the following diagnosis codes when submitting claims for the Blood-based Biomarker test HCPCS G0327:

Z12.11 Encounter for screening for malignant neoplasm of colon, OR, Z12.12 Encounter for screening for malignant neoplasm of rectum

The following table published in *CMS Program Memorandum, Transmittal AB-03-033, Change Request #2580, February 28, 2003: Promoting Colorectal Cancer Screening as a part of National Colorectal Cancer Awareness Month Medicare Coverage and Procedure Codes* provides a synopsis of CMS National Coverage Policy discussed in this article The table was updated with coverage of HCPCS code G0328 effective January 1, 2004.

COLORECTAL CANCER SCREENING GUIDELINES		
Colorectal Cancer Screening Test/Procedure	**CPT/HCPCS Code**	**Medicare Coverage**
Screening Fecal-Occult Blood Test	82270 G0328	Once every 12 months for patients age 50 and older.
Screening Flexible Sigmoidoscopy	G0104	Once every 48 months for patients age 50 and older when performed by a doctor of medicine or osteopathy, or a physician assistant, nurse practitioner, or clinical nurse specialist.
Screening Colonoscopy *- individual at high risk*	G0105	Once every 24 months for patients at any age who are at high risk for colorectal cancer, when performed by a doctor of medicine or osteopathy.
Screening Colonoscopy *- individual not meeting criteria for high risk*	G0121	Once every 10 years but not within 48 months of a screening sigmoidoscopy for patients at any age who are not at high risk, when performed by a doctor of medicine or osteopathy.
Screening Barium Enema*, alternative to G0104 (screening sigmoidoscopy)**	G0106	Physicians may substitute a barium enema examination for flexible sigmoidoscopy every 4 years for patients age 50 and older.
Screening Barium Enema*, alternative to G0105 (screening colonoscopy)**	G0120	Physicians may substitute a barium enema examination for colonoscopy every 2 years for high-risk patients.
Screening Barium Enema *not performed as an*	G0122	This service is denied as noncovered, because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

alternative to G0105 or G0104.		
Colorectal cancer screening; blood-based biomarker	*G0327*	Once every 3 years for Medicare beneficiaries when performed in a Clinical Laboratory Improvement Act (CLIA)-certified laboratory, when ordered by a treating physician and when all of the requirements listed above are met.

Effective January 1, 2018, *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; only the deductible is waived.*

Effective January 1, 2015 through December 31, 2017, anesthesia professionals who furnish a separately payable anesthesia service (CPT code 00810) in conjunction with a screening colonoscopy shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:

- Modifier 33 – Preventive Services: when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Effective January 1, 2018, *coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 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 (G0500 or 99153) are reported with only the PT modifier; only the deductible is waived.*

The Affordable Care Act waives the Part B deductible for colorectal cancer screening tests that become diagnostic. The Medicare policy is that the deductible is waived for all surgical procedures (Current Procedural Terminology (CPT) code range of 10000 to 69999) furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services. A modifier "PT" has been created effective January 1, 2011 which providers and practitioners should append to a least one CPT code in the surgical range of 10000 to 69999 on a claim for services furnished in this scenario.

For claims submitted to the Part A MAC:

Claims for colorectal cancer screening tests may be submitted for bill types 12X, 13X, 22X, 23X, 83X, 85X (CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.6).

Effective April 1, 2006, CMS Publication 100-04, *Medicare Claims Processing Manual,* Transmittal 821, Change Request #4272, February 1, 2006, requires fiscal intermediaries (FIs) to allow colorectal cancer screening HCPCS 82270 and G0328 to be billed on TOB 14X for non-patient laboratory specimens.

Claims for bill types other than 22X or 23X should be submitted using the following revenue codes: *030X for 82270, G0328; 032X for G0106, G0120, G0122* (CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.6); and 036X, 049X, 519, 075X, or 076X (for G0104, G0105, G0121).

Claims for bill types 22X or 23X should be submitted using the following revenue codes: *030X for 82270, G0328;*

032X for G0106; and 075X for G0104 (CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.6).

Effective January 19, 2021, a blood-based biomarker test is covered as an appropriate colorectal cancer screening test. Claims may be submitted with Revenue code 030X, and bill types 13X, 14X or 85X.

For claims submitted to the Part B MAC:

When performing a **screening** rather than a diagnostic sigmoidoscopy or colonoscopy through a stoma, use CPT code 44799 (Unlisted procedure, intestine). It should be entered in Item 19 of the CMS-1500 claim form or the electronic equivalent, whether the examination is more similar to a screening sigmoidoscopy or screening colonoscopy.

Modifier QW should be appended to HCPCS code G0328 to indicate a CLIA waived test.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

Effective January 1, 2016, HCPCS code G0464 was deleted and replaced with CPT code 81528.

Group 1 Codes: (10 Codes)

CODE	DESCRIPTION
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
82270	BLOOD, OCCULT, BY PEROXIDASE ACTIVITY (EG, GUAIAC), QUALITATIVE; FECES, CONSECUTIVE COLLECTED SPECIMENS WITH SINGLE DETERMINATION, FOR COLORECTAL NEOPLASM SCREENING (IE, PATIENT WAS PROVIDED 3 CARDS OR SINGLE TRIPLE CARD FOR CONSECUTIVE COLLECTION)
G0104	COLORECTAL CANCER SCREENING; FLEXIBLE SIGMOIDOSCOPY
G0105	COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL AT HIGH RISK
G0106	COLORECTAL CANCER SCREENING; ALTERNATIVE TO G0104, SCREENING SIGMOIDOSCOPY, BARIUM ENEMA
G0120	COLORECTAL CANCER SCREENING; ALTERNATIVE TO G0105, SCREENING COLONOSCOPY, BARIUM ENEMA.

CODE	DESCRIPTION
G0121	COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL NOT MEETING CRITERIA FOR HIGH RISK
G0122	COLORECTAL CANCER SCREENING; BARIUM ENEMA
G0327	COLORECTAL CANCER SCREENING; BLOOD-BASED BIOMARKER
G0328	COLORECTAL CANCER SCREENING; FECAL OCCULT BLOOD TEST, IMMUNOASSAY, 1-3 SIMULTANEOUS

CPT/HCPCS Modifiers

N/A

ICD-10-CM Codes that Support Medical Necessity

Group 1 Paragraph:

Routine screening examinations:

Group 1 Codes: (3 Codes)

CODE	DESCRIPTION
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

Group 2 Paragraph:

Screening examinations for persons at high risk: (HCPCS Codes G0105 and G0120)

Group 2 Codes: (166 Codes)

CODE	DESCRIPTION
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

CODE	DESCRIPTION
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
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
C78.5	Secondary malignant neoplasm of large intestine and 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
D12.1	Benign neoplasm of appendix
D12.2	Benign neoplasm of ascending colon
D12.3	Benign neoplasm of transverse colon
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
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

CODE	DESCRIPTION
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
D37.1	Neoplasm of uncertain behavior of stomach
D37.2	Neoplasm of uncertain behavior of small intestine
D37.3	Neoplasm of uncertain behavior of appendix
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
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

CODE	DESCRIPTION
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
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
CODE	DESCRIPTION
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

CODE	DESCRIPTION
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
K52.0	Gastroenteritis and colitis due to radiation
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
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

CODE	DESCRIPTION
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
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z09	Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
Z15.09	Genetic susceptibility to other malignant neoplasm
Z80.0	Family history of malignant neoplasm of digestive organs

CODE	DESCRIPTION
Z83.71	Family history of colonic polyps
Z85.00	Personal history of malignant neoplasm of unspecified digestive organ
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
Z85.05	Personal history of malignant neoplasm of liver
Z86.004	Personal history of in-situ neoplasm of other and unspecified digestive organs
Z86.010	Personal history of colonic polyps
Z87.19	Personal history of other diseases of the digestive system

ICD-10-CM Codes that DO NOT Support Medical Necessity

N/A

ICD-10-PCS Codes

N/A

Additional ICD-10 Information

N/A

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/19/2021	R11	Article revised to add coverage criteria for Blood-based Biomarker Tests (effective January 19, 2021) in accordance with NCD 210.3 - Screening for Colorectal Cancer (CRC).
10/01/2019	R10	Based on CMS Transmittal 2427, the article was revised effective for dates of service on or after 10/1/2019, to add ICD-10 code Z86.004, and delete ICD-10 codes C18.9 and D12.6 from the Group 2 list of payable diagnoses. Bill type and Revenue codes were removed from the article. Guidance on these codes is available in the Bill type and Revenue code sections.
01/01/2018	R9	Based on CMS Transmittal No. 3844, Publication 100-04, *Medicare Claims Processing Manual,* Change Request 10181, August 18, 2017, the article was revised to include the following two paragraphs: Effective January 1, 2018, *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; only the deductible is waived.* Effective January 1, 2018, *coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 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 (G0500 or 99153) are reported with only the PT modifier; only the deductible is waived.* The following paragraph was revised to include "through December 31, 2017": Effective January 1, 2015 through December 31, 2017, anesthesia professionals who furnish a separately payable anesthesia service (CPT code 00810) in conjunction with a screening colonoscopy shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:
09/26/2017	R8	Based on CMS Transmittal No. 3848, Publication 100-04, *Medicare Claims Processing*

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		Manual, Change Request #10199, August 25, 2017, the article was revised to reflect changes to the national language regarding HCPCS code G0464 and CPT code 81528. Add Bill Type Code 14X which is only applicable for non-patient laboratory specimens.
10/01/2016	R7	Based on CMS Transmittal 1792, Publication 100-20 One-Time Notification, Change Request #9861, February 3, 2017, ICD-10-CM codes C49.A3, C49.A4 and C49.A5 were added to Group 2 with coverage retroactive for dates of service on or after October 1, 2016. ICD-10-CM code Z12.10 was moved from Group 2 to Group 1.
10/01/2016	R6	Due to the annual ICD-10-CM code update for 2017, ICD-10-CM code K52.2 was deleted from Group 2 of the "ICD-10-CM Codes that Support Medical Necessity" section of the article.
05/01/2016	R5	Based on CMS Transmittal 1630, Publication 100-20 One-Time Notification, Change Request #9540, February 26, 2016, added 42 ICD-10-CM codes which were inadvertently removed with Change Request #9252 with coverage retroactive for dates of service on or after October 1, 2015. Corrected the Bill Type Codes to align with CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 60.6. Minor template language changes made.
01/01/2016	R4	HCPCS code G0464 was deleted on December 31, 2015 and replaced with CPT code 81528 for dates of service on or after January 1, 2016 in the “Article Text” and “CPT/HCPCS Codes” sections.
10/01/2015	R3	Based on a provider request, ICD-10-CM code Z08 was added to the “Covered ICD-10-CM Codes” section.
10/01/2015	R2	Based on CMS Transmittal No. 1537, Publication 100-20 One-Time Notification, Change Request #9252, August 21, 2015, additional ICD-10-CM codes have been included in the "Covered ICD-10-CM Codes" section. ICD-10-CM codes from Groups 3 and 4 have been merged into Group 2. Based on CMS Transmittal No. 3319, Publication 100-04, *Medicare Claims Processing Manual,* Change Request #9115, August 6, 2015, the article was revised to reflect additions and changes to the national language. Removed place of service coding guidelines.
10/01/2015	R1	Due to the annual HCPCS update for 2015, HCPCS code G0464 was added to the “CPT/HCPCS Codes” section. HCPCS code G0464 was added to the following coding guidelines:

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		Claims for colorectal cancer screening services (CPT code 82270 and HCPCS codes G0104, G0105, G0106-26, G0120-26, G0121, G0328, G0328-QW and G0464) are payable under Medicare Part B in the following places of service: office (11), urgent care facility (20), outpatient hospital (22), hospital emergency room (23), ambulatory surgical center (24), skilled nursing facility (31), nursing facility (32) and independent clinic (49). NOTE: HCPCS codes G0105 and G0121 are allowed a facility fee when performed in an ambulatory surgical center (24). Claims for codes 82270, G0328, G0328-QW and G0464 are also payable under Medicare Part B in the following places of service: federally qualified health center (50), independent laboratory (81) and rural health clinic (72). Based on CMS Transmittal No. 3146, Publication 100-04, *Medicare Claims Processing Manual,* Change Request #8874, December 11, 2014, the following requirement was added: Effective January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service (CPT code 00810) in conjunction with a screening colonoscopy shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible: • Modifier 33 – Preventive Services: when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used. Based on CMS Transmittal No. 3096, Publication 100-04, *Medicare Claims Processing Manual,* Change Request #8881, October 17, 2014, the following requirement was revised to include a physician assistant, nurse practitioner, or clinical nurse specialist: *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, nurse practitioner, or clinical nurse specialist.*

Associated Documents

Related Local Coverage Documents

N/A

Related National Coverage Documents

N/A

Statutory Requirements URLs

N/A

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

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Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

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