CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12299	**Date: October 12, 2023**
	Change Request 13017

Transmittal 11865 issued February 16, 2023, is being rescinded and replaced by Transmittal 12299, dated October 12, 2023, to provide clarifications on CMS policy and related claims processing instructions for our approach to colonoscopies within the context of a complete colorectal cancer screening by revising the policy section with additional verbiage, adding Business Requirement (BR) 13017 - 04.5.3, and revising BRs 13017-04.1 and 13017 - 04.4 to 13017 - 04.10. This CR is amended to remove the requirement (and corresponding Pub. 100-04 narrative) that contractors shall return to provider/ return as un-processable certain screening colonoscopy claims that do not include the KX modifier. This correction does not make any revisions to the companion Pub. 100-02 or Pub. 100-03; all revisions are associated with Pub. 100-04. All other information remains the same.

SUBJECT: An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final Rule, Including (1) Removal of Selected NCDs (NCD 160.22 Ambulatory EEG Monitoring), and, (2) Expanding Coverage of Colorectal Cancer Screening - Full Agile Pilot CR

I. SUMMARY OF CHANGES: The purpose of this omnibus Change Request (CR) is to make contractors aware of policy updates resulting from changes specified in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule (87 FR 69404), published in the Federal Register on 11/18/2022. The policy updates include removal of one selected National Coverage Determination (NCD) : Ambulatory Electroencephalographic (EEG) Monitoring (NCD 160.22). Separately, the policy updates also include policies to expand colorectal cancer screening coverage by 1) reducing the minimum age for certain CRC screening tests from 50 to 45 years and 2) expanding the regulatory definition of CRC screening tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based test returns a positive result (a complete colorectal cancer screening).

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 13, 2023 - For requirements subject to revision in amended CR only; February 27, 2023 - Requirements Implementation Date; April 3, 2023 - For Release Tracking Purposes Only

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	18/1/1.2 – Table of Preventive and Screening Services
R	18/60/60.1.1 - Deductible and Coinsurance
R	18/60/60.2 - HCPCS Codes, Frequency Requirements, and Age Requirements
R	18/60/60.7 - Medicare Summary Notice (MSN) Messages
R	18/60/60.8 - 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:12299	Date: October 12, 2023	Change Request: 13017

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I. GENERAL INFORMATION

A. Background: NCD Removal:

National coverage policy NCD 160.22 Ambulatory EEG Monitoring was made effective on June 16, 1984. The NCD describes Ambulatory EEG monitoring is a diagnostic procedure for patients in whom a seizure diathesis is suspected but not defined by history, physical or resting EEG.

CRC Screening:

Medicare coverage for colorectal cancer (CRC) screening tests under Part B are described in statutes (sections 1861(s)(2)(R), 1861(pp), 1862(a)(1)(H) and 1834(d) of the Act), regulation (42 CFR 410.37), and National Coverage Determination (NCD) (Section 210.3 of the NCD Manual, Publication (Pub) 100-03). The following CRC screening tests currently include a payment and/or coverage limitation that the individual be at least 50 years of age or older:

- Screening Flexible Sigmoidoscopy Test (G0104)
- Screening Guaiac-based Fecal Occult Blood Test (gFOBT) (82270)
- Screening Immunoassay-based Fecal Occult Blood Test (iFOBT) (G0328)
- Screening The Cologuard™ – Multi-target Stool DNA (sDNA) Test (81528)
- Screening Barium Enema Test (G0106, G0120)
- Screening Blood-based Biomarker Tests (G0327)

In addition, and separately, Medicare policy has historically considered a colonoscopy that follows a positive result from a non-invasive stool-based CRC test (gFOBT, iFOBT or sDNA) to be a diagnostic procedure (and not a screening procedure) because the positive result from the non-invasive stool-based test represented a sign of illness. Beneficiary cost sharing is not applicable to a screening colonoscopy (G0105, G0121) (as a specified preventive screening procedure), but is applicable to a diagnostic colonoscopy.

B. Policy: The CY 2023 PFS includes the following policy updates, effective January 1, 2023:

NCD Removal:

CMS periodically identifies and proposes to remove NCDs through public notice and comment rulemaking in the PFS that no longer contain clinically pertinent and current information or no longer reflect current medical practice.

In the CY 2023 PFS Final Rule, CMS finalized a proposal to remove NCD 160.22 EEG Monitoring. In the absence of this NCD, coverage determinations will be made by the Medicare Administrative Contractors (MACs) under section 1862(a)(1)(A) of the Social Security Act (the Act).

CRC Screening (Adjusting the minimum age limitations for certain tests):

The minimum age payment and/or coverage limitation for the following CRC screening tests is now reduced to 45 years of age or older:

- Screening Flexible Sigmoidoscopy Test
- Screening Guaiac-based Fecal Occult Blood Test (gFOBT)
- Screening Immunoassay-based Fecal Occult Blood Test (iFOBT)
- Screening The Cologuard™ – Multi-target Stool DNA (sDNA) Test
- Screening Barium Enema Test
- Screening Blood-based Biomarker Tests

Screening Colonoscopy (HCPCS G0105 and G0121) will continue to not have a minimum age limitation. We are not modifying existing maximum age limitations (where applicable).

CRC Screening (A Complete Colorectal Cancer Screening):

A positive result from a non-invasive stool-based CRC screening test no longer requires that a following colonoscopy be billed as a diagnostic colonoscopy. CRC screening tests now include the flexibility that a colonoscopy following a positive result from a Medicare covered non-invasive stool-based CRC screening test (gFOBT, iFOBT or sDNA) may be billed as a screening colonoscopy. The flexibility for the screening colonoscopy within this scenario is described as a complete colorectal cancer screening. See 42 CFR 410.37(k). We now understand both the non-invasive stool-based test and the follow-on colonoscopy to both be part of a continuum of a complete CRC screening. Beneficiary cost sharing will not apply to the non-invasive stool-based test nor the following screening colonoscopy in this scenario because both are specified preventive screening services. In support of this new policy, the frequency limitations for screening colonoscopy in 42 CFR 410.37(g) will not be applicable to the screening colonoscopy that follows a positive result from a stool-based test in a complete colorectal cancer screening scenario. The policy goal of not applying frequency limitations to the follow-on screening colonoscopy after a non-invasive stool-based test returns a positive result is to remove barriers and encourage the patient to proceed to the colonoscopy procedure soon after the positive result from the stool-based test.

We highlight the following explanatory notes:

• The policies, coding and claims processing for screening colonoscopy prior to January 1, 2023, remain in place and unchanged with the exception for the flexibility allowed for a screening colonoscopy furnished in the context of a complete colorectal cancer screening scenario described in this CR.

• A complete colorectal cancer screening is a flexibility that allows a screening colonoscopy that follows a positive result from a non-invasive stool-based CRC screening test. This flexibility allows for a claim for a

screening colonoscopy to be approved and paid that may have historically been denied either because: 1) the presence of a positive result from a prior non-invasive stool-based CRC screening test would require that the colonoscopy be billed as a diagnostic instead of screening test, or, 2) due to screening colonoscopy frequency limitations.

• When a practitioner furnishes a screening colonoscopy within the context of a complete colorectal cancer screening (following a positive result from a non-invasive stool-based CRC screening test), the practitioner shall identify the complete colorectal cancer screening context by applying the -KX modifier to the claim for the screening colonoscopy.

• It is the responsibility of the furnishing practitioner, not the contractors, to appropriately apply the -KX modifier to claims for screening colonoscopy to indicate it was furnished in the context of a complete colorectal cancer screening.

• The contractors shall continue to process claims for screening colonoscopy not in the context of a complete colorectal cancer screening (that do not include the -KX modifier) under prior established policies and claims processing instructions.

• The contractors shall not deny a claim for the screening colonoscopy furnished within the context of a complete colorectal cancer screening (identified by the -KX modifier applied by the furnishing practitioner on the claim) for the reason that a positive result from a prior stool-based test is considered a signal of illness that requires the colonoscopy be billed as a diagnostic instead of screening service under Medicare policy.

• The contractors shall not deny the claim for the screening colonoscopy furnished within the context of a complete colorectal cancer screening (identified by the -KX modifier applied by the furnishing practitioner on the claim) for the reason of screening colonoscopy frequency limitations because they do not apply when the screening colonoscopy is furnished within the context of a complete colorectal cancer screening.

• A prior claim for a non-invasive stool-based CRC screening test in the beneficiary's claims history shall not be a mandatory prerequisite to the contractor approving and paying for a screening colonoscopy furnished in the context of a complete colorectal cancer screening (identified by the KX modifier applied by the furnishing practitioner on the claim). Our reason for this clarification is that we would not want to delay the patient in proceeding to obtain a colonoscopy while waiting for the claim for the prior stool-based test to be submitted and processed in the claims processing system. We would expect the positive result from a prior non-invasive stool-based CRC screening test to be evidenced in the patient's medical record and claims history during a later compliance review, if applicable.

Separate Note: Contractors shall apply the instructions in CR 12656 for screening colonoscopy procedures G0105 and G0121 and screening flexible sigmoidoscopy G0104 that become a diagnostic or therapeutic service (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). This CR includes updates to the Claims Processing Manual sections that align with the updated policies and instructions in CR 12656. See the CY 2022 PFS Final Rule (86 FR 64996) for additional information and policy description.

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	
13017 - 04.1	**NCD Removal:**	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Contractors shall determine coverage for Ambulatory EEG Monitoring effective for claims with dates of service on or after January 1, 2023. NOTE: Also see Publication (Pub) 100-03, NCD Manual Chapter 1 Section 160.22.									
13017 - 04.2	**NCD Removal:** Contractors shall be aware of the conforming changes in the NCD Manual at section 160.22 ending NCD coverage for EEG Monitoring.	X	X							
13017 - 04.3	**NCD Removal:** Contractors shall end-date any editing related to Ambulatory EEG Monitoring effective January 1, 2023.	X	X							
13017 - 04.4	**CRC Screening (adjusting minimum age limitations):** Contractors shall modify current editing to allow CRC Screening tests (HCPCS codes G0104, G0106, G0120, G0327, G0328, 81528, and 82270) to be performed on beneficiaries age 45 and older effective for claims with dates of service on or after January 1, 2023. The maximum age of 85 year individuals for 81528 and G0327 shall remain unchanged. NOTE: also see Pub 100-02 Benefit Policy Manual Chapter 15 Section 280.2 and Pub 100-03, NCD Manual, Chapter 1 Section 210.3.					X			X	
13017 - 04.4.1	**CRC Screening (adjusting minimum age limitations):**	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Contractors shall not search for or adjust claims for colorectal cancer CRC screening tests described in BR 13017-04.4, that have been paid prior to April 3, 2023. However, contractors shall adjust claims brought to their attention.									
13017 - 04.5	**CRC Screening (a complete colorectal cancer screening):** Effective for claims with dates of service on or after January 1, 2023, contractors shall allow a screening colonoscopy (HCPCS code G0105 and G0121) furnished within the context of a complete colorectal cancer screening (follows a Medicare covered CRC non-invasive stool-based test HCPCS code G0328, 81528, or 82270 that returns a positive result) that might otherwise be denied because 1) a prior signal of illness resulting from the positive result from the prior non-invasive stool-based test or 2) due to screening colonoscopy frequency limitations.	X	X						X	
13017 - 04.5.1	**CRC Screening (a complete colorectal cancer screening):** Effective for claims with dates of service on or after January 1, 2023, the contractor shall be aware a screening colonoscopy furnished within the context of a complete colorectal cancer screening shall be identified by the presence of the -KX modifier on the claim for the screening colonoscopy (HCPCS code G0105 and G0121). It is the responsibility of the practitioner to appropriately apply the KX modifier to the claim. The	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	contractor shall not search for or identify claims for a screening colonoscopy furnished in the context of a complete colorectal cancer screening for claims that do not include the KX modifier. Note: Contractors shall continue to process claims for screening colonoscopy not in the context of a complete colorectal cancer screening (that do not include the -KX modifier) under prior established policies and claims processing instructions.									
13017 - 04.5.2	**CRC Screening (a complete colorectal cancer screening):** Effective for claims with dates of service on or after January 1, 2023, contractors shall not deny a claim for a screening colonoscopy ((HCPCS code G0105 and G0121) that is furnished within the context of a complete colorectal cancer screening (identified by the presence of the -KX modifier described in 13017- 04.5.1) because a positive result from a prior non-invasive stool-based CRC screening test (HCPCS code G0328, 81528, or 82270) indicates a signal of illness that would necessitate the colonoscopy be billed as a diagnostic service.	X	X							
13017 - 04.5.3	**CRC Screening (a complete colorectal cancer screening):** Effective for claims with dates of service on or after January 1, 2023, contractors shall not apply frequency limitations to a screening colonoscopy (HCPCS codes G0105 and G0121) that is furnished within	X	X						X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the context of a complete colorectal cancer screening (described in 13017-04.5 and identified by the -KX modifier described in 13017-04.5.1).									
13017 - 04.5.4	**CRC Screening (a complete colorectal cancer screening):** Contractors shall be aware that the next eligible date in frequency calculations for screening colonoscopy shall not be impacted by a screening colonoscopy furnished in the context of a complete colorectal cancer screening described in BR 13017 - 04. 5.	X	X						X	
13017 - 04.5.5	**CRC Screening (a complete colorectal cancer screening):** Contractors shall be aware that a screening colonoscopy furnished in the context of a complete colorectal cancer screening described in BR 13017 - 04. 5 shall not post the SCRN aux file.	X	X						X	
13017 - 04.6	**CRC Screening (minimum age adjustment):** Contractors shall be aware of and make any necessary systems changes for the new MSN message 18.29 in Pub 100-04, Medicare Claims Processing Manual, Chapter 18, Section 60.7	X	X							
13017 - 04.7	**CRC Screening (minimum age adjustment):** Contractors shall be aware of and make any necessary systems changes for the replacement Remittance Advice Message N129 in Pub 100-04, Medicare Claims Processing Manual, Chapter 18, Section	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	60.8.									
13017 - 04.8	**CRC Screening (a complete colorectal cancer screening):** Contractors shall not search for or adjust claims for CRC screening colonoscopies, described in BR 13017-04.5. However, contractors shall adjust claims with dates of service on or after January 1, 2023 that are brought to their attention and/ or that the contractors become aware that may have been processed inconsistent with our policy intentions, as clarified in this amended CR.	X	X							
13017 - 04.9	**CRC Screening:** Contractors shall engage in user acceptance testing when the code is delivered.	X	X							
13017 - 04.10	FISS shall participate in calls to create the epic, business requirements and determine the goals of this CR.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13017 - 04.11	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.					

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

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

1.2 – Table of Preventive and Screening Services

(Rev. 12299; Issued:10-12-23; Effective:01-01-23; Implementation:11-13-23)

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	***Not Rated**	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished prior to January 1, 2017	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	**B**	WAIVED
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished on or after January 1, 2017	76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	**B**	WAIVED
Cardiovascular Disease Screening	80061	Lipid panel	**A**	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	**B**	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**

	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	***Not Rated**	WAIVED

Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	***Not Rated**	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	**B**	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**

	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	**B**	WAIVED

	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	A	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	**A**	WAIVED

	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	**A**	WAIVED
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	**A**	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	**A**	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	**A**	WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	**A**	WAIVED
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED

	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	**A**	WAIVED
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	**B**	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	**B**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	77063	Screening digital breast tomosynthesis, bilateral		WAIVED
	77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	B	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites, axial skeleton, (e.g., hips, pelvis, spine), including vertebral fracture assessment.		WAIVED

	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED

NOTE:

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.

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.

For dates of service in calendar year (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.

Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	**A**	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED

	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	***Not Rated**	Coins. Applies & Ded. is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coins. Applies & Ded. is waived

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	**A**	WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
	81528	Oncology (colorectal) screening, quantitative real -time target and signal amplification of 10 DNA markers		WAIVED
	G0327	Colorectal cancer screening; blood-based biomarker Colon ca scrn;bld-bsd biomrk		WAIVED
	G0102	Prostate cancer screening; digital rectal examination	**D**	Not Waived

Prostate Cancer Screening	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	I	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived

Influenza Virus Vaccine			For the Medicare-covered codes for the influenza vaccines approved by FDA for current influenza vaccine season, please go to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html	
	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	**B**	WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use		WAIVED
	90654	Influenza virus vaccine, split virus, preservative free, for intradermal use, for adults ages 18-64		WAIVED

	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6- 35 months of age, for intramuscular use		WAIVED

	90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED
	90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED
	90672	Influenza virus vaccine, live, quadrivalent, for intranasal use		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED

	90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use		WAIVED
	90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED

Pneumococcal Vaccine	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	B	WAIVED
	90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use		WAIVED
	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
Hepatitis B Vaccine	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	**A**	WAIVED

	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use		WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use		WAIVED
	G0010	Administration of Hepatitis B vaccine	**A**	WAIVED
Hepatitis C Virus Screening	G0472	Screening for Hepatitis C antibody	**B**	WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple- step method, HIV-1 or HIV-2, screening	**A**	WAIVED
	G0433	Infectious agent antigen detection by enzyme- linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2 , screening		WAIVED
Smoking Cessation for services furnished prior to October 1, 2016	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Smoking Cessation for services furnished on or after October 1, 2016	99406	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED
	99407	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	***Not Rated**	WAIVED
	G0439	Annual wellness visit, including PPPS, subsequent visit		WAIVED

Intensive Behavioral	G0447	Face-to-Face Behavioral Counseling for Obesity, 15 minutes	**B**	WAIVED
Therapy for Obesity	G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)		
Lung Cancer Screening	G0296	Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)	**B**	WAIVED
	G0297	Low dose CT scan (LDCT) for lung cancer screening		
COVID-19 Vaccine	See link	https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies		WAIVED

60.1.1 – Deductible and Coinsurance

(Rev. 12299; Issued:10-12-23; Effective:01-01-23; Implementation:11-13-23)

There is no deductible and no coinsurance or copayment for the FOBTs (HCPCS G0107, G0328), flexible sigmoidoscopies (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 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.

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 (HCPCS G0464). (Note: Beginning January 1, 2016, CPT code 81528 replaced G0464).

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 or after January 1, 2023, colorectal cancer screening tests include a screening colonoscopy (HCPCS codes G0105, G0121) that follows a non-invasive stool- based test (HCPCS codes 82270, G0328 and 81528). 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.

NOTE: A 25% coinsurance applies for all colorectal cancer screening colonoscopies (HCPCS G0105 and G0121) performed in ASCs and non-OPPS hospitals effective for services performed on or after January 1, 2007. The 25% coinsurance was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

A 25% coinsurance also applies for colorectal cancer screening sigmoidoscopies (HCPCS G0104) performed in non-OPPS hospitals effective for services performed on or after January 1, 2007. Beginning January 1, 2008, colorectal cancer screening sigmoidoscopies (HCPCS G0104) are payable in ASCs, and a 25% coinsurance applies. The 25% coinsurance for colorectal cancer screening sigmoidoscopies was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

Effective for claims with dates of service on or after January 1, 2011, coinsurance and deductible do not apply to screening colonoscopies, screening sigmoidoscopies, and other specified colorectal cancer screening services.

60.2 - HCPCS Codes, Frequency Requirements, and Age Requirements

(Rev. 12299; Issued:10-12-23; Effective:01-01-23; Implementation:11-13-23)

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

- CPT 82270* (HCPCS G0107*) - Colorectal cancer screening; fecal-occult blood tests, 1-3 simultaneous determinations;
- HCPCS G0104 - Colorectal cancer screening; flexible sigmoidoscopy;
- HCPCS G0105 - Colorectal cancer screening; colonoscopy on individual at high risk;
- HCPCS G0106 - Colorectal cancer screening; barium enema; as an alternative to HCPCS G0104, screening sigmoidoscopy;
- HCPCS G0120 - Colorectal cancer screening; barium enema; as an alternative to HCPCS G0105, screening colonoscopy.

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.
- HCPCS G0122 - Colorectal cancer screening; barium enema (non-covered).

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 G0107*):

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

Effective for services furnished on or after October 9, 2014, the following code is added for colorectal cancer screening services:

- HCPCS G0464 - Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3). Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528.

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

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

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

***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.

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 code 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.

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 count 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.

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; Barium Enema; as an Alternative to Screening Sigmoidoscopy is reduced to 45 years and older.

CPT 82270* (HCPCS G0107*) – **Colorectal Cancer Screening; FOBT, 1-3 Simultaneous Determinations**

Effective for services furnished on or after January 1, 1998, screening FOBT (code 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, 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 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.

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 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 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 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 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.

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; Barium Enema; as an Alternative to Screening Colonoscopy 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.

HCPCS G0464 (Replaced with CPT 81528) - Multitarget sDNA Colorectal Cancer Screening Test - Cologuard™

Effective for dates of service on or after October 9, 2014, colorectal cancer screening using the Cologuard™ multi-target 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 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 adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

Effective for claims with dates of service on or after October 9, 2014, providers shall report at least ONE of the following diagnosis codes when submitting claims for the Cologuard™ multi-target sDNA test:

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

Z12.12 Encounter for screening for malignant neoplasm of rectum

NOTE: Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Multitarget sDNA Colorectal Cancer Screening Test - Cologuard™ is reduced to 45 years and older.

HCPCS G0327- Colorectal Cancer Screening - Blood-based Biomarker Tests

Blood-based DNA testing detects molecular markers of altered DNA that are contained in the cells shed into the lumen of the large bowel by colorectal cancer and pre-malignant colorectal epithelial neoplasia.

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 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 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).

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

- FDA market authorization with an indication for colorectal cancer screening; 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 of colorectal cancer compared to the recognized standard (accepted as colonoscopy at this time), as minimal threshold levels, based on the pivotal studies included in the FDA labeling.

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

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening - Blood-based Biomarker Tests is reduced to 45 years and older.

HCPCS G0122 – Colorectal Cancer Screening; Barium Enema

The code is not covered by Medicare.

60.7 - Medicare Summary Notice (MSN) Messages

(Rev. 12299; Issued:10-12-23; Effective:01-01-23; Implementation:11-13-23)

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, or a barium enema 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, or a barium enema 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 or a barium enema 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 82270* (HCPCS G0107*) or HCPCS G0328), flexible sigmoidoscopy (HCPCS G0104), screening colonoscopy (HCPCS G0105), or a screening barium enema (HCPCS G0106 or G0120), 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. For example: If the claims history indicates a payment has been made for HCPCS G0120 and an incoming claim is submitted for HCPCS G0105 within 24 months, the incoming claim should be denied.

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.

***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.

F. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) 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:

15.19: "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.

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"

NOTE: Due to system requirement, the Fiscal Intermediary Standard System (FISS) has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

G. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) because the beneficiary is not between the ages of *45* and 85, use:

15.19 - "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.

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."

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

H. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) because the claim does not contain all of the ICD-10 diagnosis codes required, use:

15.19 - "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.

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"

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

I. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) on institutional claims when submitted on a TOB other than 13X, 14X, and 85X, use:

21.25 - This service was denied because Medicare only covers this service in certain settings.

Spanish Version: “El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

60.8 - Remittance Advice Codes

(Rev. 12299; Issued:10-12-23; Effective:01-01-23; Implementation:11-13-23)

All messages refer to ANSI X12N 835 coding.

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

Claim Adjustment Reason Code (CARC) 6 “*T*he 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, or a screening barium enema 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) or a screening barium enema (HCPCS G0120) 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 (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) 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 (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) 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 (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) 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 claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) when claims are submitted on a TOB other than 13X, 14X, or 85X, use:

- CARC 170: "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N95 – "This provider type/provider specialty may not bill this service."

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.