LCD for Colorectal Cancer Screening (L1211)

Contractor Information

Contractor Name
Palmetto GBA

Contractor Number
00380

Contractor Type
FI

LCD Information

LCD ID Number
L1211

LCD Title
Colorectal Cancer Screening

Contractor's Determination Number
01A-0018-L

AMA CPT / ADA CDT Copyright Statement

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CMS National Coverage Policy

Title XVIII of the Social Security Act §1862(a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Title XVIII of the Social Security Act, §1862(a)(7) excludes routine physical examinations.

The Balanced Budget Act of 1997 §4104 provides coverage of colorectal cancer screening subject to established criteria.

Benefits Improvement Protection Act (BIPA) 2000 expands coverage for screening colonoscopies for all individuals, not just those at high risk.

CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, §§280.2.1- 280.2.5

CMS Manual System, Pub 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 4, §210.3
LCD Information

LCD ID Number

CMS Manual System, Pub 100-04, Medicare Claims Processing Manual, Chapter 7, §80.6

CMS Manual System, Pub 100-04, Medicare Claims Processing Manual, Chapter 18, §§60- 60.7

CMS Manual System, Pub 100-08, Medicare Program Integrity, Transmittal 63, dated January 23, 2004, Change Request 3010

Primary Geographic Jurisdiction

South Carolina

Secondary Geographic Jurisdiction

Oversight Region

Region IV

Original Determination Effective Date

For services performed on or after 04/01/2002

Original Determination Ending Date

Revision Effective Date

For services performed on or after 10/01/2008

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

Cancer is the second most common cause of death in the United States. Cancer of the colon and rectum (colorectal cancer) is an uncontrolled growth of anaplastic cells. Specific tumor types include adenocarcinoma, carcinoid tumor, leiomyosarcoma, and lymphoma. Colorectal tumors generally occur after age 40, equally in men and women.

Earlier diagnosis and treatment of certain cancers and better health practices have improved the outlook for individuals diagnosed with cancer. There are four separate Medicare benefits related to colorectal disease.
LCD Information

LCD ID Number

§4104 of the Balanced Budget Act of 1997 provides coverage for colorectal cancer screening tests/procedures for the early detection of colorectal cancer. Coverage includes the following procedures furnished for the purpose of early detection of colorectal cancer:

- screening fecal-occult blood test
- screening flexible sigmoidoscopy
- screening colonoscopy, for high risk individuals for colorectal cancer; and
- screening barium enema (as an alternative to screening flexible sigmoidoscopy or screening colonoscopy)

A specific diagnosis is required for this high risk group (see ICD-9 Codes That Support Medical Necessity).

§103 of the Benefits Improvement and Protection Act (BIPA) 2000 provides coverage for a colorectal cancer screening test/screening colonoscopy for beneficiaries not at high risk. No specific diagnosis is required for this low risk group.

For the coverage criteria for diagnostic colonoscopy, please refer to the Local Coverage Determination Diagnostic Colonoscopy- #01A-0014-L.

The coverage criteria for Fecal Occult Blood Testing (FOBT) is found in the CMS Manual System, Pub 100-03, Medicare National Coverage Determinations (Internet Only Manual).

High risk individuals are defined by CMS as those persons with one or more of the following:

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

Coverage Topic

Colorectal Cancer Screening - Barium Enema
Colorectal Cancer Screening - Colonoscopy
Colorectal Cancer Screening - Fecal Occult Blood Test
Colorectal Cancer Screening - Flexible Sigmoidoscopy

Coding Information
Coding Information

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 policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

12x  Hospital-inpatient or home health visits (Part B only)
13x  Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
14x  Non-Patient Laboratory Specimens
22x  SNF-inpatient or home health visits (Part B only)
23x  SNF-outpatient (HHA-A also)
71x  Clinic-rural health
73x  Clinic-independent provider based FQHC (eff 10/91)
85x  Special facility or ASC surgery-rural primary care hospital (eff 10/94)

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 policy 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 policy should be assumed to apply equally to all Revenue Codes.

030X  Laboratory-general classification
032X  Radiology diagnostic-general classification
036X  Operating room services-general classification
049X  Ambulatory surgical care-general classification
050X  Outpatient services-general classification (deleted 9/93)
051X  Clinic-general classification
052X  Free-standing clinic-general classification
075X  Gastro-intestinal services-general classification
0760  Treatment or observation room-general classification
0761  Treatment or observation room-treatment room (eff 9/93)
0769  Treatment or observation room-other
Coding Information

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 policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

CPT/HCPCS Codes

**NOTE:** Code G0121 has been assigned by CMS for reporting colorectal screening performed on a beneficiary who does NOT meet the criteria for high risk. This code must be reported when the screening procedure is not covered. For dates of service on or after July 1, 2001, this code is a covered service.

**NOTE:** 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 (G0105) or a screening flexible sigmoidoscopy (code G0104). This service is a non-covered Medicare service.

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.

G0121  COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL NOT MEETING CRITERIA FOR HIGH RISK

G0122  COLORECTAL CANCER SCREENING; BARIUM ENEMA

G0328  COLORECTAL CANCER SCREENING; FECAL OCCULT BLOOD TEST, IMMUNOASSAY, 1-3 SIMULTANEOUS

ICD-9 Codes that Support Medical Necessity

196.2
Coding Information

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 policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

SECONDARY AND UNSPECIFIED MALIGNANT NEOPLASM OF INTRA-ABDOMINAL LYMPH NODES
211.3 BENIGN NEOPLASM OF COLON
211.4 BENIGN NEOPLASM OF RECTUM AND ANAL CANAL
235.2 NEOPLASM OF UNCERTAIN BEHAVIOR OF STOMACH INTESTINES AND RECTUM
235.5 NEOPLASM OF UNCERTAIN BEHAVIOR OF OTHER AND UNSPECIFIED DIGESTIVE ORGANS
555.0 - 555.9 REGIONAL ENTERITIS OF SMALL INTESTINE - REGIONAL ENTERITIS OF UNSPECIFIED SITE
556.0 - 556.9 ULCERATIVE (CHRONIC) ENTEROCOLITIS - ULCERATIVE COLITIS UNSPECIFIED
558.1 GASTROENTERITIS AND COLITIS DUE TO RADIATION
558.2 TOXIC GASTROENTERITIS AND COLITIS
558.3 ALLERGIC GASTROENTERITIS AND COLITIS
558.42 EOSINOPHILIC COLITIS
558.9 OTHER AND UNSPECIFIED NONINFECTIOUS GASTROENTERITIS AND COLITIS
562.10 DIVERTICULOSIS OF COLON (WITHOUT HEMORRHAGE)
562.11 DIVERTICULITIS OF COLON (WITHOUT HEMORRHAGE)
562.12 DIVERTICULOSIS OF COLON WITH HEMORRHAGE
562.13 DIVERTICULITIS OF COLON WITH HEMORRHAGE
564.00 - 564.09 UNSPECIFIED CONSTIPATION - OTHER CONSTIPATION
564.81 - 564.89 NEUROGENIC BOWEL - OTHER FUNCTIONAL DISORDERS OF INTESTINE
569.0 - 569.3 ANAL AND RECTAL POLYP - HEMORRHAGE OF RECTUM AND ANUS
792.1 NONSPECIFIC ABNORMAL FINDINGS IN STOOL CONTENTS
Coding Information

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 policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

793.4 NONSPECIFIC ABNORMAL FINDINGS ON RADILOGICAL AND OTHER EXAMINATION OF GASTROINTESTINAL TRACT

V10.00 PERSONAL HISTORY OF MALIGNANT NEOPLASM OF UNSPECIFIED SITE IN GASTROINTESTINAL TRACT

V10.05 PERSONAL HISTORY OF MALIGNANT NEOPLASM OF LARGE INTESTINE

V10.06 PERSONAL HISTORY OF MALIGNANT NEOPLASM OF RECTUM RECTOSIGMOID JUNCTION AND ANUS

V10.07 PERSONAL HISTORY OF MALIGNANT NEOPLASM OF LIVER

V12.70 PERSONAL HISTORY OF UNSPECIFIED DIGESTIVE DISEASE

V12.72 PERSONAL HISTORY OF COLONIC POLYPS

V16.0 FAMILY HISTORY OF MALIGNANT NEOPLASM OF GASTROINTESTINAL TRACT

V18.51 FAMILY HISTORY, COLONIC POLYPS

V19.8 FAMILY HISTORY OF OTHER CONDITION

V76.41 SCREENING FOR MALIGNANT NEOPLASMS OF THE RECTUM

V76.51 SPECIAL SCREENING FOR MALIGNANT NEOPLASMS COLON

Diagnoses that Support Medical Necessity

N/A

ICD-9 Codes that DO NOT Support Medical Necessity

N/A
Coding Information

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 policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity
N/A

General Information

Documentation Requirements
The attending/consulting physician must supply a written order for the specific screening test performed.

All studies must have an interpretation on file and should be available for review. For studies done at the request of a referring physician, the order/requisition, with the medical indication, should be kept in the patient’s medical record.

Documentation supporting the medical necessity should be legible, maintained in the patient’s medical record, and must be made available to the Intermediary upon request.

Appendices
N/A

Utilization Guidelines

Medicare Coverage For Colorectal Cancer Screenings:

Screening Fecal-Occult Blood Tests (FOBT) (Codes 82270 & G0328)

Effective for services furnished on or after January 1, 1998, one screening FOBT (82270) is covered for beneficiaries who have attained age 50, at a frequency of once every 12 months. 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.

Effective for services furnished on or after January 1, 2004, payment may be made for an immunoassay-based FOBT (G0328) as an alternative to the guaiac-based FOBT (82270). Medicare will pay for only one covered FOBT per year, either 82270 or G0328, but not both.

Screening FOBT, immunoassay (G0328) 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.

Screening Flexible Sigmoidoscopies (Code G0104)
General Information

Documentation Requirements

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

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

Screening colonoscopies (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 G0105 screening colonoscopy was performed).

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

Screening barium enema examinations may be paid as an alternative to a screening sigmoidoscopy (code G0104). The same frequency parameters for screening sigmoidoscopies apply. In the case of an individual aged 50 or over, payment may be made for a screening barium enema examination (code G0106) performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed.

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

Screening barium enema examinations may be paid as an alternative to a screening colonoscopy (code G0105) examination. The same frequency parameters for screening colonoscopies 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 (code G0120) performed after at least 23 months have passed following the month in which the last screening barium enema or the last screening colonoscopy was performed.

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 (code 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 G0121 screening colonoscopy was performed.)

· If the individual would otherwise qualify to have covered a G0121 screening colonoscopy based on the above but has had a covered screening flexible sigmoidoscopy (code G0104), then he or she may have covered a G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered G0104 flexible sigmoidoscopy was performed.

G0122 - Colorectal Cancer Screening; Barium Enema

This code is not covered by Medicare.
General Information

Documentation Requirements

Sources of Information and Basis for Decision


Advisory Committee Meeting Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the Intermediary, this policy was developed in cooperation with advisory groups, which include representatives from the affected provider community. Advisory Committee Meeting Date: November 5, 2001.

Start Date of Comment Period

10/05/2001

End Date of Comment Period

11/19/2001

Start Date of Notice Period

02/15/2002

Revision History Number

Revision #16, 10/01/2008
Revision #15, 08/07/2008
Revision #14, 01/04/2008
Revision #13, 01/01/2007
Revision #12, 10/01/2006
Revision #11, 02/23/2006
Revision #10, 11/02/2005
Revision #9, 07/05/2005
Revision #8, 11/22/2004
Revision #7, 10/01/2004
Revision #6, 05/28/2004
Revision #5, 01/12/2004
Revision #4, 11/28/2003
Revision #3, 10/01/2003
Revision #2, 05/07/2003
Revision #1, 10/01/2002

Revision History Explanation

Revision #16, 10/01/2008
Under *AMA/CPT & ADA/CDT Copyright Statement* changed the copyright date from 2007 to 2008. Under *ICD-9 Codes That Support Medical Necessity* added ICD-9 code 558.42. This revision becomes effective 10/01/2008.
General Information

Documentation Requirements

Revision #15, 08/07/2008
This LCD has had its annual validation. No changes made. This revision becomes effective on 08/07/2008.

Revision #14, 01/04/2008
Under CMS National Coverage Policy revised the publication numbers for the cited manuals “100-2”, “100-3”, “100-4” and “100-8” to now read “100-02”, “100-03”, “100-04” and “100.08”. Deleted Change Requests 1552, 2996, 2874, 4005, and 5292. Under Indications and Limitations of Coverage and/or Medical Necessity added verbiage related to coverage criteria for Fecal Occult Blood Testing (FOBT). Under Utilization Guidelines deleted the verbiage, “…Except for Skilled Nursing Facilities” from the title. Deleted the section titled, “Medicare Coverage for Certain Colorectal Cancer Screenings at Skilled Nursing Facilities.” This policy was reviewed for annual validation. This revision becomes effective 01/04/2008.

Revision #13, 01/01/2007

Revision #12, 10/01/2006
Under AMA/CPT and ADA/CDT Copyright Statement section of this policy the copyright date has been updated from 2005 to 2006. Under CMS National Coverage Policy the verbiage was changed. Under ICD-9 Codes That Support Medical Necessity V18.5 was extended to a 5th digit to now read V18.51. Under Sources of Information and Basis for Decision the references were placed in the AMA citation format. Under Revision History #10 corrected a typographical error to delete, “under ICD-9 Codes That Support Medical Necessity.” This policy was reviewed for annual validation. This revision becomes effective 10/01/2006.

Revision #11, 02/23/2006
Under CMS National Coverage Policy added sections 280.2.3, 280.2.4 and 280.2.5 to the following reference - CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 15, Sections 280.2.1- 280.2.2 and added Change Request 4005. This revision becomes effective 02/23/2006.

Revision #10, 11/02/2005
Under Advisory Committee Meeting Notes corrected a typographical error-changed “effected” to “affected”. Under Revision History #9 corrected a typographical error to delete the verbiage “added the first sentence”. This revision becomes effective 11/02/2005.

Revision #9, 07/05/2005
Under CMS National Coverage Policy added sections 1862 (a)(1)(A) and 1862 (a)(7) of Title XVIII of the Social Security Act. Added Part 4 to CMS Manual System, Pub 100-3, Medicare National Coverage Determinations and Change Request 3010.Deleted Change Request 2822. Under Indications and Limitations of Coverage and/or Medical Necessity, paragraph 2 changed “three separate Medicare Benefits…” to “four”. Verbiage added related to Section 4104 of the BBA of 1997 and Section 103 of BIPA 2000 and defining of high-risk individuals. Under Bill Type Codes deleted 18x and 21x. Under Revenue Codes added 51x, 0760, 0761, and 0769. Under CPT/HCPCS Codes added G0122 and “Notes” sections. Under ICD-9 Codes That Support Medical Necessity added multiple ICD-9 codes indicated with the subscript date of 07/05/05. Under Documentation Requirements added paragraph #3. Under Utilization Guidelines added verbiage. Under Advisory Committee Meeting Notes changed “outpatient hospitals” to “…the effected provider community.” This revision becomes effective 07/05/2005.

Revision #8, 11/22/2004
Under AMA/CPT and ADA/CDT Copyright Statement section of this policy, deleted the reference to CDT-4 copyright language, as this policy does not contain CDT-4 codes or descriptions. This revision becomes effective 11/22/2004.
General Information

Documentation Requirements

Revision #7, 10/01/2004
Under AMA/CPT and ADA/CDT Copyright Statement section of this policy the copyright date has been updated from 2003 to 2004. Under Type of Bill Code section of this policy, Federally Qualified Health Centers (73x) has been added. Under CPT/HCPCS Codes section of the policy the HCPCS code G0122 has been deleted. These changes become effective 10/01/2004.

Revision #6, 05/28/2004

NOTE: Change Request 2874 becomes effective July 1, 2004.

Revision #5 01/12/2004
Under CMS National Coverage Policy section of the policy manual citations added to reflect Change Request 2996 dated December 19, 2003. Under CPT/HCPCS Codes section of the policy HCPCS code G0328 was added. Under the Coding Guidelines section of the policy #1 was expanded to address screening fecal occult blood tests performed on or after January 1, 2004. These changes become effective 01/12/2004.

Revision #4 11/28/2003
Under CMS National Coverage Policy section of this policy the manual citations have been changed to reflect the Internet Only Manual (IOM). These changes become effective 11/28/2003.

Revision #3, 10/01/2003
Under the AMA CPT Copyright Statement section of this policy the copyright date has been changed from 2002 to 2003. Under the CMS National Coverage Policy section PM AB-03-114, dated August 1, 2003, change request 2822. Under the Coding Guidelines section of this policy #6 has been added to address incomplete colonoscopies. These changes become effective on 10/01/2003.

Revision #2, 05/07/2003
Addition of ICD-9 CM codes 569.0-569.3, 792.1 and 793.4. These changes become effective 05/07/2003.

Revision #1 10/01/2002
Under Type of Bill Code section, Critical Access Hospital (85x) has been added to the policy. This change becomes effective 10/01/2002.

This LCD was converted from an LMRP on 5/18/2004

Reason for Change

ICD9 Addition/Deletion
Maintenance (annual review with new changes, formatting, etc.)
General Information

Documentation Requirements

Last Reviewed On Date
09/17/2008

Related Documents

Article(s)
A34606 - Colonoscopy – Coding Guidelines

LCD Attachments
There are no attachments for this LCD.

Other Versions
Updated on 07/30/2008 with effective dates 08/07/2008 - 09/30/2008
Updated on 12/07/2007 with effective dates 01/04/2008 - 08/06/2008
Updated on 11/10/2007 with effective dates 01/01/2007 - 01/03/2008
Updated on 12/22/2006 with effective dates 01/01/2007 - N/A
Updated on 09/14/2006 with effective dates 10/01/2006 - 12/31/2006
Updated on 07/06/2006 with effective dates 02/23/2006 - 09/30/2006
Updated on 07/02/2006 with effective dates 02/23/2006 - N/A
Updated on 02/17/2006 with effective dates 02/23/2006 - N/A