## 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

CPT codes, descriptions and other data only are copyright 2008 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. © 2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

### **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

## **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

## **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.

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)
COLORECTAL CANCER SCREENING; FLEXIBLE SIGMOIDOSCOPY
COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL AT HIGH RISK
COLORECTAL CANCER SCREENING; ALTERNATIVE TO G0104, SCREENING SIGMOIDOSCOPY, BARIUM ENEMA
COLORECTAL CANCER SCREENING; ALTERNATIVE TO G0105, SCREENING COLONOSCOPY, BARIUM ENEMA.
COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL NOT MEETING CRITERIA FOR HIGH RISK
COLORECTAL CANCER SCREENING; BARIUM ENEMA
COLORECTAL CANCER SCREENING; FECAL OCCULT BLOOD TEST, IMMUNOASSAY, 1-3 SIMULTANEOUS

## **ICD-9** Codes that Support Medical Necessity

## **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

## **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.

7	93.4	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF GASTROINTESTINAL TRACT
V	710.00	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF UNSPECIFIED SITE IN GASTROINTESTINAL TRACT
V	710.05	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF LARGE INTESTINE
V	710.06	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF RECTUM RECTOSIGMOID JUNCTION AND ANUS
V	710.07	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF LIVER
V	712.70	PERSONAL HISTORY OF UNSPECIFIED DIGESTIVE DISEASE
V	712.72	PERSONAL HISTORY OF COLONIC POLYPS
V	716.0	FAMILY HISTORY OF MALIGNANT NEOPLASM OF GASTROINTESTINAL TRACT
V	718.51	FAMILY HISTORY, COLONIC POLYPS
V	719.8	FAMILY HISTORY OF OTHER CONDITION
V	776.41	SCREENING FOR MALIGNANT NEOPLASMS OF THE RECTUM
V	776.51	SPECIAL SCREENING FOR MALIGNANT NEOPLASMS COLON

## **Diagnoses that Support Medical Necessity**

N/A

## ICD-9 Codes that DO NOT Support Medical Necessity

N/A

## **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)

## **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.

## **Documentation Requirements**

#### **Sources of Information and Basis for Decision**

Fauci AS, Braunwald E, Isselbacher KJ, et al, eds. Harrison's Principles of Internal Medicine. 14th ed. 1998.

Thompson JM, et al. Mosby's Manual of Clinical Nursing. 2nd Ed. St. Louis: The C.V. Mosby Company; 1989.

### **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.

## **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

Under CMS National Coverage Policy added Change Request 5292. Under CPT/HCPCS Codes deleted CPT code G0107 and added CPT code 82270. Under Utilization Guidelines replaced CPT code 82270 for G0107 throughout the verbiage. This revision becomes effective 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.

## **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

Reverted Local Medical Review Policy (LMRP) to Local Coverage Determination (LCD). Under AMA/CPT and ADA/CDT Copyright Statement, added the American Dental Association copyright date. Under CMS National Coverage Policy section of the policy, deleted IOM citation, CMS Manual System, Pub 100-4, Medicare Claims Processing, Chapter 3, Section 30.1.1. and CMS Manual System, Pub 100-4, Medicare Claims Processing, Chapter 18, Section 20.4. Added Change Requests 2996, 1552, and 2874. These changes become effective 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.)

## **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