MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - Understanding the Remittance Advice: *A Guide for Medicare Providers, Physicians, Suppliers, and Billers* serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. To order your copy today, go to the Medicare Learning Network Product Ordering page at http://www.cms.hhs.gov/MLNProducts on the CMS website.

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Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscsopy

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for colorectal cancer screening services provided to Medicare beneficiaries.

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services to clarify billing instructions for the Medicare beneficiary who 1) presents for a screening colonoscopy (or flexible sigmoidoscopy), 2) has no gastrointestinal symptoms, and 3) during their screening colonoscopy (or flexible sigmoidoscopy), have an abnormality identified (such as a polyp, etc.) which is biopsied or removed.

Background

CMS has become aware of confusion regarding billing for colorectal screening arising because of wording in the Medicare Physician Fee Schedule (MPFS) Final Rule for 2007 (Federal Register, Vol. 71, No. 231, page 69665, December 1, 2006 (See the MPFS Final Rule at http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1321fc.pdf on the CMS website).

The relevant section of the 2007 MPFS states, regarding screening colonoscopies, that:

``*if during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal." Based on this statutory language, in such instances the test or procedure is no longer classified as a ``screening test." Thus, the deductible would not be waived in such situations.*

The above scenario can be restated as follows:

- A patient presents for a screening colonoscopy (or flexible sigmoidoscopy), and the patient has no gastrointestinal symptoms.

- During the subsequent screening colonoscopy (or flexible sigmoidoscopy), an abnormality is identified (such as a polyp, etc.), and it is biopsied or removed.

CMS advises that, whether or not an abnormality is found, if a service to a Medicare beneficiary starts out as a screening examination (colonoscopy or sigmoidoscopy), then the primary diagnosis should be indicated on the form CMS-1500 (or its electronic equivalent) using the ICD-9 code for the screening examination.

As an example, the above scenario should be billed as follows using claim form CMS-1500 (or its electronic equivalent):

- Item 21 (Diagnosis or Nature of Illness or Injury)

    - Indicate the Primary Diagnosis using the International Classification of Diseases, Ninth Revision, Clinical Modification, (ICD-9-CM) code for the screening examination (colonoscopy or sigmoidoscopy), and

    - Indicate the Secondary Diagnosis using the ICD-9-CM code for the abnormal finding (polyp, etc.).

  - For example, V76.51 (Special screening for malignant neoplasms, Colon) would be used as the first listed code, while the secondary code might be 211.3 (Benign neoplasm of other parts of digestive system, Colon).

- Item 24D (Procedures, Services, or Supplies)

  - Indicate the procedure performed using the CMS Healthcare Common Procedure Coding System/Common Procedure Terminology (HCPCS/CPT) code for the procedure (biopsy or polypectomy), and

- Item 24E (Diagnosis Pointer)

  - Enter only "2" (to link the procedure (polypectomy or biopsy) with the abnormal finding (polyp, etc.)

A Medicare beneficiary undergoing a screening colonoscopy (no symptoms and no abnormal findings prior to the procedure) will be responsible for the deductible if a polyp is identified and either biopsied or removed.

When there is no need for a therapeutic procedure, the appropriate HCPCS G-code is reported with the ICD-9-CM code reflecting the indication. Effective January 1, 2007, CMS began waiving the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS G-codes listed in the following table:

HCPCS Screening Code	Descriptor
G0104	Colorectal cancer screening: Flexible sigmoidoscopy
G0105 G0121	Colorectal cancer screening: Colonoscopy on individual at high risk; Colorectal cancer screening: Colonoscopy on individual not meeting criteria for high risk
G0106	Colorectal cancer screening: Barium enema as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening: Barium enema as an alternative to G0105, screening colonoscopy

Additional Information

For related MLN Matters articles on colorectal cancer screenings, see articles SE0710 and MM5387, which are available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf*, respectively, on the CMS website.

If you have any questions, please contact your Medicare carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.