



The Guide to
**Medicare
Preventive
Services**

for Physicians, Providers, Suppliers, and Other Health Care Professionals



Colorectal Cancer Screening

Overview

Colorectal cancer is the third leading cause of cancer deaths in the United States, and the risk for it increases with age.⁸ The American Cancer Society estimated that 57,100 Americans died of colorectal cancer in 2003.⁹ Patients with colon cancer rarely display any symptoms, and the cancer can progress unnoticed and untreated until it becomes fatal. The most common symptom of colorectal cancer is bleeding from the rectum. Other common symptoms include cramps, abdominal pain, intestinal obstruction, or a change in bowel habits. Fortunately, colorectal cancer can be prevented if diagnosed and treated early.

Colorectal cancer is usually found in individuals age 50 or older. Colorectal screenings are performed to diagnose or determine a beneficiary's risk for developing colon cancer. Medicare covers colorectal screening tests to help find pre-cancerous polyps (growths in the colon) so they can be removed before they turn into cancer. Colorectal screening may consist of several different screening tests/procedures to test for polyps or colorectal cancer. Each colorectal screening test/procedure can be used alone or in combination with each other.

Medicare's coverage of colon cancer screening procedures was created as a result of the implementation of the Balanced Budget Act of 1997 (BBA). The BBA provided coverage of various colon-screening examinations subject to certain coverage, frequency, and payment limitations. Effective July 1, 2001, subsequent legislation expanded the colorectal screening benefit to include colonoscopies for Medicare beneficiaries not at high risk for developing colorectal cancer and amended the conditions for payment for a screening sigmoidoscopy.

The colorectal screening tests/procedures covered by Medicare are:

- ▶ Fecal Occult Blood Test (Stool Test)
- ▶ Flexible Sigmoidoscopy
- ▶ Colonoscopy
- ▶ Barium Enema

The **Fecal Occult Blood Test** checks for occult or hidden blood in the stool. A beneficiary's health care provider gives a fecal occult blood test card to the beneficiary, and the test can be performed at home. Stool samples are taken and placed on the test cards and then returned to the doctor or a laboratory. The fecal occult blood test is:

1. A guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools.

AND

2. An immunoassay (or immunochemical) test for antibody activity in which the beneficiary completes the test by taking the appropriate number of samples according to the specific manufacturer's instructions.

⁸ Amanda Gardner. HealthScout. January 19, 2005. *Cancer Now the Leading Killer of Americans* [online]. ScoutNews, LLC, HealthScout Network, 2005 [cited 27 January 2005]. Available from the World Wide Web: (www.healthscout.com/news/1/523520/main.html).

⁹ The American Cancer Society, Inc. January 22, 2003. *ACS Cancer Facts & Figures 2003 Released: Special Section Addresses Smoking Cessation* [online]. Atlanta, GA: The American Cancer Society, Inc., 2003 [cited 28 September 2004]. Available from the World Wide Web: (www.cancer.org/docroot/NWS/content/NWS_1_1x_ACS_Cancer_Facts_Figures_2003_Released.asp).

The **Flexible Sigmoidoscopy** is used to check for polyps or cancer in the rectum and the lower third of the colon. This procedure is sometimes used in combination with the fecal occult blood test and is administered by inserting a short, thin, flexible, lighted tube into the rectum of the beneficiary.

The **Colonoscopy** is a procedure similar to the flexible sigmoidoscopy, except a longer, thin, flexible, lighted tube is used to check for polyps or cancer in the rectum and the entire colon. Most polyps and some cancers can be found and removed during the procedure.

The **Barium Enema** is a procedure in which the beneficiary is given an enema with barium. X-rays are taken of the colon that allows the physician to see the outline of the beneficiary's colon to check for polyps or other abnormalities.

Risk Factors

The high risk factors associated with colorectal cancer include any of the following:

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

Coverage Information

Medicare provides coverage of colorectal cancer screening tests for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however there is no minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the beneficiary is at high risk. The covered tests/procedures are:

- ▶ Screening fecal occult blood tests
- ▶ Screening flexible sigmoidoscopy
- ▶ Screening colonoscopy
- ▶ Screening barium enema as an alternative to a screening flexible sigmoidoscopy or screening colonoscopy

Coverage for colorectal screening is provided as a Medicare Part B benefit. The beneficiary will pay nothing for the fecal occult blood test (there is no deductible and no coinsurance or copayment for this benefit). For all other procedures, the coinsurance or copayment applies after the yearly Medicare Part B deductible has been met. If the flexible sigmoidoscopy or colonoscopy procedure is performed in a hospital outpatient department, the beneficiary will pay 25% of the Medicare-approved amount after meeting the yearly Medicare Part B deductible.

The following are the coverage requirements for each screening test/procedure.

Screening Fecal Occult Blood Test

Medicare provides coverage of a screening fecal occult blood test annually (i.e., at least 11 months have passed following the month in which the last covered screening fecal occult blood test was performed) for beneficiaries age 50 and older. This screening requires a written order from the beneficiary's attending physician. Payment may be made for an immunoassay-based fecal occult blood test as an alternative to the guaiac-based fecal occult blood test. However, Medicare will only provide coverage for one fecal occult blood test per year, not both.

Who Can Order the Screening Fecal Occult Blood Test?

The Screening Fecal Occult Blood Test requires a written order from a doctor of medicine or osteopathy 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.

Screening Flexible Sigmoidoscopy

Medicare provides coverage of a screening flexible sigmoidoscopy for beneficiaries age 50 or older based on beneficiary risk. A doctor of medicine or osteopathy must order this screening.

Who Can Perform a Screening Flexible Sigmoidoscopy?

Screening flexible sigmoidoscopies must be performed by a doctor of medicine or osteopathy, or by a physician assistant, nurse practitioner, or clinical nurse specialist.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening flexible sigmoidoscopy once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for beneficiaries at high risk for colorectal cancer.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening flexible sigmoidoscopy once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for beneficiaries age 50 and older who are not at high risk for colorectal cancer. If the beneficiary has had a screening colonoscopy within the preceding 10 years, then the next screening flexible sigmoidoscopy will be covered only after at least 119 months have passed following the month in which the last covered colonoscopy was performed.

If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed.

Screening Colonoscopy

Medicare provides coverage of a screening colonoscopy for beneficiaries age 50 or older, and for others at high risk, without regard to age. A doctor of medicine or osteopathy must perform this screening.

Who Can Order and Collect a Screening Colonoscopy?

Screening colonoscopies must be ordered and collected by a doctor of medicine or osteopathy.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening colonoscopy (or a screening barium enema) once every 2 years for beneficiaries at high risk for colorectal cancer.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening colonoscopy once every 10 years but not within 47 months of a previous screening sigmoidoscopy.

If during the course of the screening colonoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed.

Screening Barium Enema

Medicare provides coverage of a screening barium enema as an alternative to either a screening sigmoidoscopy or a high risk screening colonoscopy. This procedure is covered for beneficiaries based on beneficiary risk.

Who Can Order and Collect a Screening Barium Enema?

The screening barium enema must be ordered and collected by a doctor of medicine or osteopathy.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening barium enema every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening barium enema was performed) for beneficiaries at high risk for colorectal cancer, without regard to age.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening barium enema once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening barium enema was performed) for beneficiaries not at high risk for colorectal cancer, but who are age 50 or older.

The screening barium enema (preferably a double contrast barium enema) must be ordered in writing after a determination that the procedure is appropriate. If the individual cannot withstand a double contrast barium enema, the attending physician may order a single contrast barium enema. The attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the estimated screening potential for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, 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 previously for the screening double contrast barium enema examination.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Colorectal cancer screening services are billed using the Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1.

| HCPCS Codes | HCPCS Code Descriptors |
|-------------|--|
| 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 |
| G0107 | Colorectal cancer screening; fecal occult blood test, 1-3 simultaneous determinations |
| 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; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations |

Table 1 - HCPCS Codes for Colorectal Screening Services

***NOTE:** Non-covered by Medicare.

Non-Covered Colorectal Cancer Screening Services

Code **G0122 (colon cancer screening; barium enema)** should be used when a screening barium enema is performed NOT as an alternative to either a screening colonoscopy (code **G0105**) or a screening flexible sigmoidoscopy (code **G0104**). This service is denied as non-covered because it fails to meet the requirements of the benefit. **The beneficiary is liable for payment.** Reporting of this non-covered code will also allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes.

Diagnosis Requirements

For the screening colonoscopy, the beneficiary is not required to have any present signs/symptoms. However, when billing for the “high risk” beneficiary, the screening diagnosis code on the claim must reflect at least one of the high risk conditions described previously.

Listed in Table 2, Table 3, and Table 4 are some examples of diagnoses that meet high risk criteria for colorectal cancer. **This is not an all-inclusive list.** There may be more instances of conditions that could be coded and would be applicable.

| ICD-9-CM Codes | ICD-9-CM Code Descriptors |
|----------------|---|
| V10.05 | Personal history of malignant neoplasm of large intestine |
| V10.06 | Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus |

Table 2 - Personal History ICD-9-CM Codes

| ICD-9-CM Codes | ICD-9-CM Code Descriptors |
|----------------|--|
| 555.0 | Regional enteritis of small intestine |
| 555.1 | Regional enteritis of large intestine |
| 555.2 | Regional enteritis of small intestine with large intestine |
| 555.9 | Regional enteritis of unspecified site |
| 556.0 | Ulcerative (chronic) enterocolitis |
| 556.1 | Ulcerative (chronic) ileocolitis |
| 556.2 | Ulcerative (chronic) proctitis |
| 556.3 | Ulcerative (chronic) proctosigmoiditis |
| 556.8 | Other ulcerative colitis |
| 556.9 | Ulcerative colitis, unspecified |

Table 3 - Chronic Digestive Disease Condition ICD-9-CM Codes

| ICD-9-CM Codes | ICD-9-CM Code Descriptors |
|----------------|---|
| 558.2 | Toxic gastroenteritis and colitis |
| 558.9 | Other and unspecified noninfectious gastroenteritis and colitis |

Table 4 - Inflammatory Bowel ICD-9-CM Codes

Billing Requirements

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS codes and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS codes, the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills for FIs

The FI will reimburse for colorectal screening when submitted on the following Types of Bills (TOBs) and associated revenue codes:

| Facility Type | Type of Bill | Revenue Codes |
|---|--------------|---------------|
| Hospital Outpatient | 13X | See Table 6 |
| Skilled Nursing Facility (SNF) Inpatient Part B | 22X | See Table 7 |
| SNF Outpatient | 23X | |
| Hospital Outpatient Surgery [subject to Ambulatory Surgical Center (ASC) Payment Limits] | 83X | See Table 6 |
| Critical Access Hospital (CAH)* | 85X | See Table 6 |

Table 5 - Facility Types, Types of Bills, and Revenue Codes for Colorectal Cancer Screening Services

***NOTE:** Method I - All technical components are paid using standard institutional billing practices.
Method II - Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X.

| Screening Test/Procedure | Revenue Code | HCPCS Code |
|--------------------------|--------------|-----------------------------------|
| Fecal Occult Blood Test | 030X | G0107, G0328 |
| Barium Enema | 032X | G0106, G0120, (G0122 non-covered) |
| Flexible Sigmoidoscopy | * | G0104 |
| Colonoscopy-High Risk | * | G0105, G0121 |

*The appropriate revenue code when reporting any other surgical procedure for bill types 13X, 83X, or 85X.

- ▶ Each FI may choose to accept other bill types for the colorectal cancer screening procedures. If another bill type is used other than 13X, 83X, or 85X, contact the local Medicare FI to determine if the particular bill type is allowed.

Table 6 - Procedure, Revenue Code, and Associated HCPCS Code for Facilities Using Types of Bills 13X, 83X, and 85X

NOTE: Hospital and Critical Access Hospital (CAH) providers should submit types of bills 13X or 85X. Outpatient surgery performed by a hospital not bound by the Outpatient Prospective Payment System (OPPS) requirements should submit TOB 83X.

Special Billing Instructions for Hospital Inpatients

When these tests/procedures are provided to inpatients of a hospital, the inpatients are covered under this benefit. However, the provider should bill on TOB 13X using the discharge date of the hospital stay to avoid editing.

Special Billing Instructions for Skilled Nursing Facilities (SNFs)

When colorectal screening tests are provided to inpatients of a SNF, the test should be billed on TOB 22X using the actual date of service.

SNFs cannot bill HCPCS codes G0105 or G0121 for a screening colonoscopy, or G0120 for a barium enema as an alternative to a screening colonoscopy. These services must be provided in a hospital, CAH, or ASC. However, SNFs may bill screening barium enema tests every 48 months as a substitute for a flexible sigmoidoscopy.

Additional information about MPFS can be found at: www.cms.hhs.gov/physicians/pfs/ on the CMS website.

Additional information about the Clinical Laboratory Fee Schedule can be found at: www.cms.hhs.gov/providers/pufdownload/clfcrst.asp on the CMS website.

Additional information about OPFS can be found at: www.cms.hhs.gov/providers/hopps/ on the CMS website.

| Screening Test/Procedure | Revenue Code | HCPCS Code |
|--------------------------------------|--------------|------------|
| Fecal Occult Blood Test | 030X | G0107 |
| Fecal Occult Blood Test, Immunoassay | 030X | G0328 |
| Barium Enema | 032X | G0106 |
| Flexible Sigmoidoscopy | 075X | G0104 |

Table 7 - Procedure, Revenue Code, and Associated HCPCS Code for SNFs

Reimbursement Information

Reimbursement of Claims by Carriers

Reimbursement for colorectal screening procedures is paid under the Medicare Physician Fee Schedule (MPFS), when billed to the Carrier. Deductible and coinsurance or copayment apply.

Reimbursement for fecal occult blood tests is paid under the Clinical Laboratory Fee Schedule, with the exception of CAHs, which are paid on a reasonable cost basis. Deductible and coinsurance do not apply for this type of screening.

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at www.cms.hhs.gov/physicians/cciedits on the CMS website.

Payment by Carriers of Interrupted and Completed Colonoscopies

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. 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 a covered colonoscopy is attempted in an ASC and is discontinued due to extenuating circumstances that threaten the well-being of the patient prior to the administration of anesthesia but after the beneficiary has been taken to the procedure room, the ASC is to suffix the colonoscopy code with the modifier -73 and payment will be reduced by 50 percent. If the colonoscopy is begun (e.g., anesthesia administered, scope inserted, incision made) but is discontinued due to extenuating circumstances that threaten the well-being of the patient, the ASC is to suffix the colonoscopy code with modifier -74 and the procedure will be paid at the full amount.

Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event that it is needed by the Medicare Contractor to document the incomplete procedure.

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.

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for colorectal screening procedures is dependent upon the type of facility. The following table lists the type of payment that facilities receive for colorectal screening services:

| Type of Colorectal Screening | Facility | Type of Payment | Deductible/Coinsurance |
|--|--|---|---|
| Fecal Occult Blood Tests (G0107 and G0328) | CAH | Reasonable Cost Basis | Deductible and coinsurance do not apply for this type of screening |
| | All other types of facilities | Clinical Laboratory Fee Schedule (Medicare pays 100% of the Clinical Laboratory Fee Schedule amount or the provider's actual charge, whichever is lower.) | |
| Flexible Sigmoidoscopy (G0104) | CAH | Reasonable Cost Basis | Deductible and coinsurance apply for this type of screening, with one exception: For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount. |
| | Hospital Outpatient Departments | Outpatient Prospective Payment System (OPPS) | |
| | SNF Inpatient (for Medicare Part B Services) | Medicare Physician Fee Schedule (MPFS) | |

Table 8 - Types of Payments Received by Facilities for Colorectal Cancer Screening Services

| Type of Colorectal Screening | Facility | Type of Payment | Deductible/Coinsurance |
|---------------------------------|---------------------------------|-----------------------|---|
| Colonoscopy (G0105) | CAH | Reasonable Cost Basis | Deductible and coinsurance apply for this type of screening, with the exception of the following: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure. For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount. |
| | Hospital Outpatient Departments | OPPS | |
| Barium Enemas (G0106 and G0120) | CAH | Reasonable Cost Basis | Deductible and coinsurance apply for this type of screening, with one exception: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure. |
| | Hospital Outpatient Departments | OPPS | |
| | SNF | MPFS | |

Table 8 - Types of Payments Received by Facilities for Colorectal Cancer Screening Services (Con't)

In addition, the colorectal screening codes must be paid at rates consistent with the colorectal diagnostic codes.

Payment by FIs of Interrupted and Completed Colonoscopies

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. The Common Working File (CWF) will not apply the frequency standards associated with screening colonoscopies. When submitting a facility claim for the interrupted colonoscopy, providers are to suffix the colonoscopy HCPCS codes with a modifier of -73 or -74 as appropriate, to indicate that the procedure was interrupted. Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event that it is needed by the Medicare Contractor to document the incomplete procedure.

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. The

frequency standards will be applied by the CWF. This policy is applied to both screening and diagnostic colonoscopies.

NOTE: Payment for covered incomplete screening colonoscopies should be consistent with payment methodologies currently in place for complete screening colonoscopies, including those contained in 42 CFR 419.44(b).

Search the Federal Register for specific sections at: www.gpoaccess.gov/cfr/retrieve.html on the Web.

Critical Access Hospital (CAH) Payment by Fiscal Intermediary (FI) of Interrupted and Completed Colonoscopies

In situations where a CAH has elected payment Method II for CAH beneficiaries, payment should be consistent with payment methodologies currently in place. As such, CAHs that elect Method II should use payment modifier -53 to identify an incomplete screening colonoscopy (physician professional service(s) billed with 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 modifier -73 or -74, as appropriate.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of colorectal cancer screening:

- ▶ The beneficiary is not at high risk and is under age 50.
- ▶ The beneficiary does not meet the criteria of being at high risk of developing colorectal cancer.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the CMS website.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the Carrier or FI.

Written Advance Beneficiary Notice (ABN) Requirements

An Advance Beneficiary Notice (ABN) is a written notice that a provider or supplier gives to a Medicare beneficiary. The purpose of the ABN is to inform a beneficiary, before he or she receives specified items or services that otherwise might be paid for by Medicare, that Medicare probably will not pay on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the CMS website.

Frequently, there is confusion regarding whether an ABN can be used to shift liability to a beneficiary for the cost of non-covered items or services. In making this decision, the provider/supplier first must determine whether the item or service meets the definition of the Medicare-covered benefit. If the item or service does not meet the definitional requirements for the Medicare-covered benefit, then the item or service will never be covered by Medicare. As a result, the beneficiary will always be liable for the cost of the item or service, and an ABN is not needed to shift liability to the beneficiary.

If the item or service meets the definition of the Medicare-covered benefit, Medicare still may not pay for the item or service if the item or service was “not reasonable and necessary” for the beneficiary on the occasion in question or if the item or service exceeds the frequency limitation for the particular benefit or falls outside the applicable time frame for receipt of the covered benefit. In these instances, an ABN may be used to shift liability for the cost of the item or service to the beneficiary. If an ABN is not issued to the beneficiary, the provider/supplier may be held liable for the cost of the item or service unless the provider/supplier is able to demonstrate that they did not know and could not reasonably have been expected to know that Medicare would not pay for the item or service.

Colorectal Cancer Screening

Resource Materials

Physician Information Resource for Medicare Website

This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.

www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule and OPPS.

www.cms.hhs.gov/providers

Medicare Learning Network

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare providers. For additional information visit the Medicare Learning Network's Medlearn web page at <http://www.cms.hhs.gov/medlearn> on the CMS website.

Preventive Services Educational Resource Web Guide

www.cms.hhs.gov/medlearn/preventiveservices.asp

Beneficiary Notices Initiative Website

www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information

www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website

www.cms.hhs.gov/physicians/cciedits

The National Cancer Institute's *Colorectal Cancer Prevention*

www.nci.nih.gov/cancertopics/pdq/prevention/colorectal/Patient/page2

The American Cancer Society's ACS Cancer Facts & Figures 2003

www.cancer.org/docroot/NWS/content/NWS_1_1x_ACS_Cancer_Facts_Figures_2003_Released.asp

Washington Publishing Company (WPC) Code Lists

WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.

www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference D of this Guide.

Notes

