Colorectal Cancer Screening and Related Ancillary Services

Last Updated: 3/12/2025 **Last Reviewed: 3/12/2025** **Originally Effective: 11/20/2015**

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM046**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** Details below

Reimbursement Guidelines

A. Colorectal Cancer Screening Services

1. Commercial plans:
   a. Preventive screening for colorectal cancer is covered in accordance with the Patient Protection and Affordable Care Act (PPACA) at 100% (no cost-sharing responsibility to the member), when the member is seeing an in-network provider.
   b. See Preventive services for adults [14] for screening methods.
   c. **Note:** The remainder of this policy focuses primarily on coding requirements and ancillary services connected with screening by sigmoidoscopy and colonoscopy methods. Other screening methods do not involve additional ancillary services.
2. Medicare Advantage plans:
   a. For Medicare Advantage plans, the provider must be Medicare-certified. Coverage for non-network preventive care is determined by the member's Medicare Advantage plan benefits; some plans may not include out-of-network benefits.
   b. Our Medicare Advantage plans cover preventive screening for colorectal cancer in accordance with Medicare Preventive Services guidelines.
   c. Please reference https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#COLO_CAN [7] for the most up-to-date information on allowable screening methods, coverage frequency for high risk and not high risk patients, procedure codes, and other specific information.
   d. **Note:** The remainder of this policy focuses primarily on coding requirements and ancillary services connected with screening by sigmoidoscopy and colonoscopy methods. Other screening methods do not involve additional ancillary services.

B. Provider Network Requirements For No Cost-Sharing Screening Benefits

1. Commercial plans:
   a. In-network providers must be used for this PPACA Preventive Benefit.
   b. Non-Network Preventive Care Services are not part of the PPACA requirements. Screening colonoscopies or sigmoidoscopies or related ancillary services performed by a non-network provider will be covered at the usual diagnostic or medical services benefit level with the applicable member cost-sharing amounts.
2. Medicare Advantage plans:
   For Medicare Advantage plans, the provider must accept Medicare but is not required to be contracted directly with our Medicare Advantage plan.

C. Coding For Preventive Services

Correctly coding preventive care services is essential for the claim to process correctly and for the member to receive available preventive benefits. In general:

- Submit preventive care services with diagnosis codes that represent health services encounters that are not for the treatment of illness or injury.
- Preventive care service claims submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis, will be processed as applicable under the member's normal medical benefits rather than preventive care coverage.
- Non-preventive care services incorrectly coded with a preventive diagnosis will not be covered as preventive care; in some cases they will be denied as a billing error, and in other cases, they may be processed as applicable under the member's normal medical benefits rather than preventive care coverage.

This policy outlines further specific coding requirements for various colorectal cancer screening services and related ancillary services. These requirements must be met to ensure the member receives their available preventive benefits.

D. Screening Colonoscopy Or Sigmoidoscopy When No Abnormalities Are Found

If a screening colonoscopy is performed and no abnormalities are found, submit the service with a procedure code specific to a screening colonoscopy (e.g., G0105, G0121).

If a screening sigmoidoscopy is performed and no abnormalities are found, submit the service with a procedure code specific to a screening sigmoidoscopy (e.g., G0104).

E. Screening Colonoscopy Or Sigmoidoscopy Converted To Diagnostic Or Therapeutic Colonoscopy Or Sigmoidoscopy

When an abnormality is encountered during screening colonoscopy or sigmoidoscopy:

1. The colonoscopy or sigmoidoscopy is still classified as a preventive service eligible for coverage at the no-member-cost-share benefit level.
   a. Submit the claim with Z12.11 (Encounter for screening for malignant neoplasm of colon) as the first-listed diagnosis code; this is the reason for the service or encounter. Use of Z12.11 in the first diagnosis position is essential to ensure the member's PPACA no-cost-share benefits are accessed.
   b. Modifier PT is to be appended to the appropriate diagnostic or therapeutic colonoscopy procedure code(s).
      i. Modifier PT is not valid to use in combination with:
         1) A procedure code with "screening" in the code description, because billing those codes indicates the screening colonoscopy was not converted to a diagnostic or therapeutic procedure.
         2) An E/M code.
      ii. Modifier PT is valid to be appended to 00811 – 00813, 45303 – 45393, 88305, and 88342.
   c. Claims with diagnostic colonoscopy/sigmoidoscopy procedure codes submitted without modifier PT appended or without Z12.11 as the first-listed diagnosis code will be processed under the member's normal medical benefit level, not preventive benefits.
2. For Commercial plans: Future colonoscopies or sigmoidoscopies are no longer eligible for Preventive screening benefits under the Patient Protection and Affordable Care Act (PPACA); they are considered diagnostic, monitoring or surveillance testing (see Monitoring or Surveillance Testing below).
3. For Medicare Advantage plans: Future colonoscopies or sigmoidoscopies may be eligible for preventive screening benefits provided criteria outlined in the CMS National Coverage Determination (NCD) for Colorectal Cancer Screening Tests are met. [11]

F. Ancillary Services for Commercial Plans

Effective for dates of service 1/1/2016 and following, ancillary services directly related to screening colonoscopies or sigmoidoscopies are considered part of the preventive service and covered at the no-member-cost-share benefit level.

1. Specialist Consultation Prior To The Screening Colonoscopy Procedure.

   A pre-procedure evaluation office visit with the physician performing the screening colonoscopy/sigmoidoscopy is classified as a preventive service eligible for coverage at the no-member-cost-share benefit level.

   a. Coding requirements:
      - i. For dates of service 7/1/2016 and after, S0285 is the most comprehensive and specific code available. For Commercial plans, S0285 may be used to report this visit. For Medicare Advantage plans, S0285 is a Status I (invalid) code, and regular E/M codes must be used.
      - ii. If S0285 is not appropriate (e.g., Medicare Advantage plans or prior to 7/1/2016), report the pre-procedure evaluation office visit with the appropriate new-patient, established-patient, or consultation evaluation and management (E/M) procedure code.
      - iii. The E/M service must be submitted with modifier 33 appended to identify that it is directly connected to a planned screening colonoscopy/sigmoidoscopy service. Use of modifier 33 is essential to ensure the member's PPACA no-cost-share benefits are accessed.
      - iv. Report Z01.818 (Encounter for other preprocedural examination) as the first-listed diagnosis code. Since the screening colonoscopy/sigmoidoscopy is not performed at this encounter, Z12.11 is not an appropriate diagnosis code.
      - v. If the pre-procedure evaluation office visit is performed at a hospital-owned provider-based clinic:
        - a) For dates of service 12/31/2018 and prior, if submitted on a CMS1450 claim, submit the visit under one of the following revenue codes:
          - 1) 0510 (Clinic–General)
          - 2) 0960 (Professional Fees–General)
          - 3) If additional revenue codes need to be configured for this benefit, submit a formal letter of request with enclosed copies of the applicable billing guidelines from CMS and the Uniform Billing Editor, and any other relevant supporting documentation.
            - i) If the need is identified due to a claim denial, submit the request as part of a formal written appeal for that claim.
            - ii) If the need is identified before a claim submission, direct the formal written request to the attention of your Medical Professional Relations Representative.
        - b) For dates of service 1/1/2019 and following:
          - 1) For Commercial lines of business, submit the service on a CMS1500 claim form with place of service 11. [D]
          - 2) For Medicare Advantage lines of business and submitted on a CMS1450 claim, submit the visit under one of the following revenue codes:
            - i) 0510 (Clinic–General)
            - ii) 0960 (Professional Fees–General)

   b. A pre-procedure evaluation office visit submitted without modifier 33 appended, diagnosis code Z01.818, or otherwise not meeting the above coding requirements, will be processed under the member's medical office visit or specialist visit benefit, not the preventive benefit.

2. Anesthesia & Conscious Sedation.
   a. Moderate (Conscious) Sedation.
      i. For dates of service in 2016 and prior, per CPT guidelines, colonoscopy and sigmoidoscopy procedure codes include conscious sedation.
         a) CPT codes 99143 – 99150 may not be reported by the same provider in conjunction with the colonoscopy/sigmoidoscopy procedure.
         b) CPT codes 99148 – 99150 may be reported by a second physician or qualified provider under limited circumstances; refer to the CPT guidelines for 99143 – 99150.
      ii. For dates of service in 2017 and following, colonoscopy and sigmoidoscopy procedure codes no longer include conscious sedation. 99151 -99157 may be separately reported. For contracted providers, eligibility for separate reimbursement will depend upon specific aspects of the provider contract.
   b. Deep Sedation or General Anesthesia.
      i. Medical necessity criteria.
         If deep sedation or general anesthesia (00810 through 2017; 00812 beginning 2018) is required for a screening colonoscopy/sigmoidoscopy, medical criteria must be met for benefits to apply. Please refer to our Medical criteria "Anesthesia for Routine Gastrointestinal Endoscopic Procedures." [C]
      ii. Coding requirements:
         a) The anesthesia service must be submitted with modifier PT appended to identify that it was performed for a screening colonoscopy/sigmoidoscopy service. Use of modifier PT is essential to ensure the member's PPACA no-cost-share benefits are accessed.
            1) For dates of service through 12/31/2017, use 00810-PT. (This code is not valid for dates of service in 2018 and following.)
            2) For dates of service beginning 1/1/2018 and following, use 00812-PT.
            3) Modifier PT is not considered valid for use with 00811. This combination will be denied. Modifier PT designates more information is available than the "not otherwise specified" of CPT code 00811, so another CPT code should be used.
            4) 2018 CPT code 00813 describes anesthesia for combined upper and lower gastrointestinal endoscopic procedures.
               i) If the lower GI endoscopy began as a colorectal cancer screening endoscopy and the upper GI endoscopy was performed in the same session, then report 00813-PT, so the anesthesia may be allowed under the member's PPACA no-cost-share benefits.
               ii) If the lower GI endoscopy did not begin as a screening procedure, report 00813 without modifier PT appended, and the member's usual medical benefit level will apply.
         b) Submit the claim with Z12.11 (Encounter for screening for malignant neoplasm of colon) as the first-listed diagnosis code; this is the reason for the service or encounter. Use of Z12.11 in the first diagnosis position is essential to ensure the member's PPACA no-cost-share benefits are accessed.
         c) If the anesthesia service is submitted on a CMS1450 claim, submit 00810-PT/00812-PT under one of the following revenue codes:
            1) 0370 (Anesthesia–General)
            2) 0963 (Professional Fees–Anesthesiologist (MD))
            3) 0964 (Professional Fees–Anesthetist (CRNA))

d) Claims for anesthesia services submitted without modifier PT appended or without a first-listed diagnosis of colorectal cancer screening will be processed under the member's usual surgical anesthesia benefit, not preventive benefits.

3. Pathology Services

When an abnormality is encountered during a screening colonoscopy/sigmoidoscopy and a biopsy or other pathology specimen is sent for pathology services, the pathology service is classified as a preventive service eligible for coverage at the no-member-cost-share benefit level.

a. Coding requirements:
   i. The pathology service (e.g., 88305) must be submitted with modifier PT appended to identify that it arose from a screening colonoscopy/sigmoidoscopy service. Use of modifier PT is essential to ensure the member's PPACA no-cost-share benefits are accessed.
   ii. Report the definitive pathologic diagnosis (e.g., K63.5) as the first-listed diagnosis, if a definitive pathologic diagnosis is available at the time the claim is filed. [4]

      A pathology service has not been completed to generate a claim until the pathologist's interpretation and report is complete and documented. Thus, the pathology conclusions are available in the report to establish the diagnosis for the claim.
   iii. Depending upon the extent of the pathology examination, and if specific extra staining technique is documented in the pathology report, 88342 is sometimes appropriate to report in addition to 88305. Modifier PT must be appended to this pathology code as well in order to ensure the member's PPACA no-cost-share screening colonoscopy benefits are accessed.
   iv. Report Z12.11 (Encounter for screening for malignant neoplasm of colon) as a second-listed or additional diagnosis on the claim.
   v. If the pathology service is submitted on a CMS1450 claim, submit the pathology code with modifier PT appended under one of the following revenue codes:
      1) 0310 (Laboratory Pathology–General)
      2) 0311 (Laboratory Pathology–Cytology)
      3) 0312 (Laboratory Pathology–Histology)
      4) 0314 (Laboratory Pathology–Biopsy)
      5) 0960 (Professional Fees–General)
      6) 0971 (Professional Fees–Laboratory)

b. Pathology services submitted without modifier PT appended (or under any other revenue code) will not be processed under the member's screening colonoscopy benefit.

4. Facility Fees, Outpatient Hospital or Ambulatory Surgery Center

If the screening colonoscopy/sigmoidoscopy is performed at an outpatient hospital or ambulatory surgery center and an abnormality is found, the facility fees are also classified as a preventive service eligible for coverage at the no-member-cost-share benefit level.

a. Coding requirements:
   i. Report the appropriate diagnostic colonoscopy/sigmoidoscopy procedure code.
   ii. Use one of the following revenue codes to report the procedure.
      1) 0360 (Operating Room Services–General)
      2) 0361 (Operating Room Services–Minor Surgery)
      3) 0490 (Ambulatory Surgical Care–General)
      4) 0517 (Clinic–Family Practice Clinic)
      5) 0750 (Gastrointestinal Services–General)
      6) 0760 (Specialty Services–General)
      7) 0761 (Specialty Services–Treatment Room)

iii. Revenue code 0510 (Clinic–General):
    1) May be used for Medicare Advantage plans and Medicaid plans.
    2) Effective for DOS January 1, 2019 and following, revenue code 0510 may not be used for Commercial plans. [D]
iv. Modifier PT is to be appended to the appropriate diagnostic or therapeutic colonoscopy procedure code(s).
v. Report Z12.11 (Encounter for screening for malignant neoplasm of colon) as the first-listed diagnosis code; this is the reason for the service or encounter. Use of Z12.11 in the first diagnosis position is essential to ensure the member's PPACA no-cost-share benefits are accessed.
vi. Report any additional findings or abnormalities encountered as additional diagnoses on the claim.

b. Facility claims with diagnostic colonoscopy/sigmoidoscopy procedure codes submitted under any other revenue code(s) or without modifier PT appended or without Z12.11 as the first-listed diagnosis code will be processed under the member's usual medical benefit level, not the preventive benefit.
c. Diagnostic colonoscopy/sigmoidoscopy procedure codes with modifier PT appended are not configured to process as colorectal cancer screening for preventive benefits on Inpatient Hospital claims, or under revenue codes for an Urgent Care Clinic (0516) or the Emergency Room (045x). Due to the contradictory nature of the services provided in these settings, colorectal cancer screening preventive services are not expected to be performed in these areas.

G. Ancillary Services for Medicare Advantage Plans

1. Specialist Consultation Prior To The Screening Colonoscopy Procedure.
    a. An E/M consultation visit is not covered by Medicare prior to a screening colonoscopy.
    b. Effective 1/1/2020 Moda Medicare Advantage plans do not cover a specialist consultation visit prior to the screening colonoscopy procedure.
    c. Should an E/M consultation visit prior to a screening colonoscopy be needed or medically necessary:
        i. Because the member's Evidence of Coverage does not list this service as non-covered, the GI physician needs to request an organization determination from our plan.
        ii. If/when we respond indicating the services are not covered, then arrange a cash transaction with the Medicare Advantage beneficiary in advance of the specialist consultation visit prior to the screening colonoscopy.
        iii. The member may not be balance-billed for a specialist consultation E/M visit if the member was not notified, and a cash transaction arranged prior to the E/M visit taking place. [E]
2. Anesthesia & Conscious Sedation.
    a. Moderate (Conscious) Sedation.
        i. For dates of service in 2016 and prior, per CPT guidelines, colonoscopy and sigmoidoscopy procedure codes include conscious sedation.
            1) CPT codes 99143 – 99150 may not be reported by the same provider in conjunction with the colonoscopy/sigmoidoscopy procedure.
            2) CPT codes 99148 – 99150 may be reported by a second physician or qualified provider under limited circumstances; refer to the CPT guidelines for 99143 – 99150.
        ii. For dates of service in 2017 and following, colonoscopy and sigmoidoscopy procedure codes no longer include conscious sedation. 99151 -99157 may be separately reported. For contracted providers, eligibility for separate reimbursement will depend upon specific aspects of the provider contract.

b. Deep Sedation or General Anesthesia.
   i. Medical necessity criteria.
      If deep sedation or general anesthesia (00810 through 2017; 00812 beginning 2018) is required for a screening colonoscopy/sigmoidoscopy, medical criteria must be met for benefits to apply. Please refer to our Medical criteria "Anesthesia for Routine Gastrointestinal Endoscopic Procedures." [C]
   ii. Coding requirements:
      1) The anesthesia service must be submitted with modifier PT appended to identify that it was performed for a screening colonoscopy/sigmoidoscopy service. The correct use of modifiers 33 or PT is essential to ensure the member's screening colonoscopy/sigmoidoscopy no-cost-share benefits are accessed.
         a) For dates of service through 12/31/2017, use 00810-PT. (This code is not valid for dates of service in 2018 and following.)
         b) For dates of service beginning 1/1/2018 and following, use 00812.
            i) Append modifier 33 (Preventive Service) to the anesthesia CPT code 00812 when you supply a separately payable anesthesia service with a screening colonoscopy (G0105 and G0121) to waive patient copayment/coinsurance and deductible. [7]
            ii) When a screening colonoscopy becomes a diagnostic colonoscopy, report anesthesia services with CPT code 00812 and append modifier PT.
         c) Modifier PT is not considered valid for use with 00811. This combination will be denied. Modifier PT designates more information is available than the "not otherwise specified" of CPT code 00811, so another CPT code should be used.
         d) 2018 CPT code 00813 describes anesthesia for combined upper and lower gastrointestinal endoscopic procedures.
            i) If the lower GI endoscopy was a colorectal cancer screening with no abnormalities found, and the diagnostic upper GI endoscopy was performed in the same session, then report 00813-33, so the anesthesia may be allowed under the member's screening colonoscopy/sigmoidoscopy no-cost-share benefits.
            ii) If the lower GI endoscopy began as a colorectal cancer screening endoscopy and the upper GI endoscopy was performed in the same session, then report 00813-PT, so the anesthesia may be allowed under the member's screening colonoscopy/sigmoidoscopy no-cost-share benefits.
            iii) If the lower GI endoscopy did not begin as a screening procedure, report 00813 without modifier PT appended, and the member's usual medical benefit level will apply.
      2) Submit the claim with Z12.11 (Encounter for screening for malignant neoplasm of colon) as the first-listed diagnosis code; this is the reason for the service or encounter. Use of Z12.11 in the first diagnosis position is essential to ensure the member's screening colonoscopy/sigmoidoscopy no-cost-share benefits are accessed.
      3) If the anesthesia service is submitted on a CMS1450 claim, submit 00810-PT/00812-PT under one of the following revenue codes:
         a) 0370 (Anesthesia–General)
         b) 0963 (Professional Fees–Anesthesiologist (MD))
         c) 0964 (Professional Fees–Anesthetist (CRNA))
      4) Claims for anesthesia services submitted without modifier PT appended or without a first-listed diagnosis of colorectal cancer screening will be processed under the member's usual surgical anesthesia benefit, not preventive benefits.

3. Pathology Services

   When an abnormality is encountered during a screening colonoscopy/sigmoidoscopy and a biopsy or other pathology specimen is sent for pathology services, the pathology service is classified as a preventive service eligible for coverage at the no-member-cost-share benefit level.

   a. Coding requirements:
      i. The pathology service (e.g., 88305) must be submitted with modifier PT appended to identify that it arose from a screening colonoscopy/sigmoidoscopy service. Use of modifier PT is essential to ensure the member's screening colonoscopy/sigmoidoscopy no-cost-share benefits are accessed.
      ii. Report the definitive pathologic diagnosis (e.g., K63.5) as the first-listed diagnosis, if a definitive pathologic diagnosis is available at the time the claim is filed. [4]

          A pathology service has not been completed to generate a claim until the pathologist's interpretation and report is complete and documented. Thus, the pathology conclusions are available in the report to establish the diagnosis for the claim.
      iii. Depending upon the extent of the pathology examination, and if specific extra staining technique is documented in the pathology report, 88342 is sometimes appropriate to report in addition to 88305. Modifier PT must be appended to this pathology code as well in order to ensure the member's screening colonoscopy/sigmoidoscopy no-cost-share screening colonoscopy benefits are accessed.
      iv. Report Z12.11 (Encounter for screening for malignant neoplasm of colon) as a second-listed or additional diagnosis on the claim.
      v. If the pathology service is submitted on a CMS1450 claim, submit the pathology code with modifier PT appended under one of the following revenue codes:
         1) 0310 (Laboratory Pathology–General)
         2) 0311 (Laboratory Pathology–Cytology)
         3) 0312 (Laboratory Pathology–Histology)
         4) 0314 (Laboratory Pathology–Biopsy)
         5) 0960 (Professional Fees–General)
         6) 0971 (Professional Fees–Laboratory)
   b. Pathology services submitted without modifier PT appended (or under any other revenue code) will not be processed under the member's screening colonoscopy benefit.

4. Facility Fees, Outpatient Hospital or Ambulatory Surgery Center

   If the screening colonoscopy/sigmoidoscopy is performed at an outpatient hospital or ambulatory surgery center and an abnormality is found, the facility fees are also classified as a preventive service eligible for coverage at the no-member-cost-share benefit level.

   a. Coding requirements:
      i. Report the appropriate diagnostic colonoscopy/sigmoidoscopy procedure code.
      ii. Use one of the following revenue codes to report the procedure.
         1) 0360 (Operating Room Services–General)
         2) 0361 (Operating Room Services–Minor Surgery)
         3) 0490 (Ambulatory Surgical Care–General)
         4) 0517 (Clinic–Family Practice Clinic)
         5) 0750 (Gastrointestinal Services–General)
         6) 0760 (Specialty Services–General)
         7) 0761 (Specialty Services–Treatment Room)

iii. Revenue code 0510 (Clinic–General):
    1) May be used for Medicare Advantage plans and Medicaid plans.
    2) Effective for DOS January 1, 2019 and following, revenue code 0510 may not be used for Commercial plans. [D]
iv. Modifier PT is to be appended to the appropriate diagnostic or therapeutic colonoscopy procedure code(s).
v. Report Z12.11 (Encounter for screening for malignant neoplasm of colon) as the first-listed diagnosis code; this is the reason for the service or encounter. Use of Z12.11 in the first diagnosis position is essential to ensure the member's screening colonoscopy/sigmoidoscopy no-cost-share benefits are accessed.
vi. Report any additional findings or abnormalities encountered as additional diagnoses on the claim.

b. Facility claims with diagnostic colonoscopy/sigmoidoscopy procedure codes submitted under any other revenue code(s) or without modifier PT appended or without Z12.11 as the first-listed diagnosis code will be processed under the member's usual medical benefit level, not the preventive benefit.
c. Diagnostic colonoscopy/sigmoidoscopy procedure codes with modifier PT appended are not configured to process as colorectal cancer screening for preventive benefits on Inpatient Hospital claims, or under revenue codes for an Urgent Care Clinic (0516) or the Emergency Room (045x). Due to the contradictory nature of the services provided in these settings, colorectal cancer screening preventive services are not expected to be performed in these areas.

H. More Frequent Colon Cancer Testing

There are times when a physician or other qualified healthcare provider determines colon cancer testing should be performed more frequently than the standard preventive screening recommendations. Which type of benefit applies to the more frequent testing varies according to the line of business.

1. Commercial Plans -- Screening Versus Diagnostic, Monitoring or Surveillance Testing
    a. More frequent colon cancer testing is considered Preventive if the patient is being observed due to family history or because of other risk factors (e.g., work environment). [10]
    b. If the patient has a diagnosis of previous colorectal cancer or has a personal history of adenomatous polyps, inflammatory bowel disease, or other risk factors for colorectal cancer, more frequent colonoscopies or sigmoidoscopies are warranted for monitoring or surveillance of a diagnosed condition.
        i. A personal history diagnosis (e.g., personal history of adenomatous polyps, inflammatory bowel disease, or other risk factors for colorectal cancer) is considered a Medical diagnosis code. [B]
        ii. When a Medical diagnosis code (such as a personal history of one of these conditions) is the reason for a colonoscopy or sigmoidoscopy, the procedure is not considered preventive screening.
        iii. Instead, colonoscopies and/or sigmoidoscopies billed with one of these personal history diagnoses are covered under the diagnostic or Medical benefit and are subject to the usual member cost-sharing requirements.
2. Medicare Advantage – Colorectal Cancer Screening for an Individual At High Risk For Colorectal Cancer.
    a. An individual at high risk for colorectal cancer means an individual with one or more of the following:[10]
        i. A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
        ii. A family history of familial adenomatous polyposis;
        iii. A family history of hereditary nonpolyposis colorectal cancer;
        iv. A personal history of adenomatous polyps; or
        v. A personal history of colorectal cancer; or

  vi. Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

b. For each type of colorectal cancer screening (multitarget sDNA test, fecal occult blood test, sigmoidoscopy, colonoscopy, or barium enema alternative) Medicare defines a different and/or more frequent schedule of testing for individuals at high risk for colorectal cancer than for those who are not at high risk.

   For the most up-to-date information, please reference: Preventive Services Chart | Medicare Learning Network® | ICN MLN006559 December 2020 (cms.gov) .

Definitions

Acronyms/Abbreviations

Acronym	Definition
AHA	American Hospital Association
AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
ICD	International Classification of Diseases
ICD-10	International Classification of Diseases, Tenth Edition
ICD-10-CM	International Classification of Diseases, Tenth Edition, Clinical Modification
ICD-10-PCS	International Classification of Diseases, Tenth Edition, Procedure Coding System
PPACA	Patient Protection and Affordable Care Act
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)

Definition of Terms

Term	Definition
Screening	"Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram)." (ICD-10[3])
Diagnostic	"The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening." (ICD-10[3])
Monitoring	Routine monitoring of an existing health condition (such as diabetes or high cholesterol) is not a routine preventive service. In this case, the word "routine" does not refer to the health insurance benefit category, but rather it means that the testing or care is considered a medical standard of care for the patient's known problem or condition. Anytime a known condition or problem exists, the testing and care for that condition is never considered preventive; instead, it is covered under the benefit category for that condition (e.g., Medical, Substance Use Disorder, Maternity, Infertility, etc.).

Term	Definition
Surveillance	Close and continuous observation or testing (Merriam Webster[6]) Surveillance testing is considered Medical if it is being done to observe or monitor a known symptom, problem, or previously identified abnormality. The diagnosis code needs to indicate the problem or symptom which is being observed or monitored. Surveillance testing is considered Preventive if the patient is being observed because of risk factors (e.g., work environment) or due to family history.

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Preventive Services versus Diagnostic and/or Medical Services." Moda Health Reimbursement Policy Manual, RPM037.
C. Moda Health's Medical criteria "Anesthesia for Routine Gastrointestinal Endoscopic Procedures."
D. "Clinic Services In the Hospital Outpatient Setting." Moda Health Reimbursement Policy Manual, RPM061.
E. "Modifiers GA, GX, GY, and GZ." Moda Health Reimbursement Policy Manual, RPM036.

Resources

1. "FAQs About Affordable Care Act Implementation (Part XXIX) And Mental Health Parity Implementation." *United States Department of Labor*. October 23, 2015. December 1, 2015. < http://www.dol.gov/ebsa/faqs/faq-aca29.html >.
2. "Colorectal Cancer: Screening." *United States Preventive Services Task Force.* October 2008: December 16, 2015. <http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening > .
3. "Screening." *ICD-10-CM Official Guidelines for Coding and Reporting 2016.* Section IV.K.
4. "Patients receiving diagnostic services only." *ICD-10-CM Official Guidelines for Coding and Reporting 2016.* Section I.C.21.c.5).
5. American Medical Association. "Moderate (Conscious) Sedation." *Current Procedural Terminology (CPT), Professional Edition*. Chicago: AMA Press.
6. Merriam Webster. Online Medical Dictionary. http://www.merriam-webster.com .
7. CMS. "Medicare Preventive Services Quick Reference Chart." ICN MLN006559 August 2020; last accessed November 30, 2020. https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
8. CMS. "Colorectal Cancer Screening." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 18 – Preventive and Screening Services, §60.
9. CMS. "Colorectal Cancer Screening Tests: Conditions for and Limitations on Coverage." Electronic Code of Federal Regulations. Title 42, Chapter IV, Subchapter B, Part 410, Subpart B, §410.37. Last accessed 1/5/2021 <https://www.ecfr.gov/cgi-bin/text-idx?SID=c9e8c54ace3ce0636691c04e54ddc95d&mc=true&node=se42.2.410_137&rgn=div8>.
10. Moda Health. "Family History." Moda Health Medical Claims Review Committee. Medical Claims Review Committee July 26, 2006 Approved Minutes Follow-up item # 4), Compliance position.
11. CMS. "Colorectal Cancer Screening Tests." *Medicare National Coverage Determinations Manual* (Pub. 100-3). Chapter 1, Part 4 – Coverage Determinations, §210.3.
12. Moda. "Preventive Services for Adults." Last accessed February 14, 2025. https://www.modahealth.com/pdfs/prev_srvcs_adults.pdf .

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
3/12/2025	Resources updated. Formatting updates. No policy changes.
3/13/2024	Formatting updates. No policy changes.
7/12/2023	Clarified provider status required for Medicare Advantage coverage and type of codes appropriate to use with modifier PT. Formatting & phrasing updates. No policy changes.
10/12/2022	Idaho added to Scope. Formatting updates, Policy History entries prior to 2022 omitted (in archive storage). No policy changes.
12/23/2015	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
11/20/2015	Original Effective Date (with or without formal documentation). Policy based on the Patient Protection and Affordable Care Act (PPACA) and CMS.