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National Government Services

Medicare Part B Preventive Services: Bone Mass Measurements, Colorectal and Prostate Cancer Screenings

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objectives

- Promote awareness of the preventive benefits covered by Medicare and assist providers in correct billing and coding for the services

Agenda

- Bone Mass Measurements
- Prostate Cancer Screening
- Colorectal Cancer Screening

Bone Mass Measurements

Did You Know?

- An estimated 10 million Americans have osteoporosis and over 34 million Americans have low bone mass, placing them at risk for osteoporosis

What Is a Bone Mass Measurement Test?

- Bone mass measurement test
  - Way to determine bone density and fracture risk for osteoporosis
  - Also referred to as bone mineral density or BMD test
  - Best way to determine bone health
- Dual energy X-ray absorptiometry
  - Most widely recognized test
  - Painless; like having X-ray
  - Measures bone density at hip and spine

Risk Factors

- Age 50 or older
- Female gender
- Family/personal history of broken bones
- Caucasian or Asian ethnicity
- Small bone structure
- Low body weight (less than 127 pounds)
- Frequent smoking or drinking
- Low-calcium diet

Coverage

- Covered once every two years when performed on “qualified” individual or more frequently if medically necessary
- “Qualified” individual meets medical indications for at least one coverage category
  - Estrogen-deficient woman at clinical risk for osteoporosis, based on medical history and other findings

Coverage Categories

- Individual with vertebral abnormalities, as demonstrated by X-ray to be indicative of osteoporosis, osteopenia or vertebral fracture
- Individual with known primary hyperparathyroidism
- Individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone or greater per day for more than three months
- Individual being monitored to assess response to FDA-approved osteoporosis drug therapy

Coverage Criteria

- Radiologic or radioisotopic procedure
- Must be performed
  - With bone densitometer (other than DPA or bone sonometer device approved by FDA)
  - For purpose of identifying bone mass, detecting bone loss or determining bone quality
- Includes physician's interpretation of results

Coverage Criteria

- Physician or NPP must provide order
  - Following evaluation of need for measurement
  - Includes determination of the medically appropriate measurement to be used
- Service must be furnished by qualified supplier or provider
  - Under appropriate level of supervision by physician
- Services must be reasonable and necessary

Medicare Coverage

- Medicare may pay for more frequent screenings when medically necessary
  - Including but not limited to the following
    - Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than three months
    - Confirming baseline BMMs to permit monitoring of beneficiaries in the future
    - Follow up bone mineral density testing to assess FDA-approved osteoporosis drug therapy until a response to such therapy has been documented over time

Coding

CPT/HCPCS Codes	Description
*G0130	Single energy X-ray absorptiometry (sexa) bone density study, one or more sites, appendicular skeleton (peripheral) (eg, radius, wrist, heel)
*76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
*77078	Computed tomography, bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)
*77080	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)

Coding

CPT/HCPCS Codes	Description
*77081	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment
*G0130,*77078, *77081, *76977	These codes must contain a valid ICD-10-CM diagnosis code indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism or steroid therapy

Coding- Additional Information

CPT/HCPCS Codes	Description
78350	Single photon absorptiometry tests are not covered

*When you see a clock symbol beside a HCPCS/CPT code it means the code/service can be billed with a prolonged preventive services add-on code (G0513 and G0514)

Deductible and coinsurance are waived for all codes listed as payable on the charts above

Coding

- See the CMS ICD-10 webpage for individual CRs and the specific ICD-10-CM codes Medicare covers for this service
  - 2022 ICD-10-CM

Prostate Cancer Screening

Prostate Cancer Screening

- Tests to detect prostate cancer
  - Screening PSA blood test
    - Must be ordered by beneficiary's physician or PA, NP, CNS or CNM
      - Fully knowledgeable about beneficiary's medical condition
      - Responsible for explaining the results of test
- Coinsurance and deductible waived

Prostate Cancer Screening

- Tests to detect prostate cancer
  - Screening DRE
    - Must be performed by doctor of medicine or osteopathy, PA, NP, CNS or CNM authorized under state law to perform examination
      - Fully knowledgeable about beneficiary's medical condition
      - Responsible for explaining results of examination
- Coinsurance and deductible applies

Eligibility

- Eligibility
  - All male Medicare beneficiaries aged 50 and older
    - Coverage begins day after 50th birthday
- Frequency
  - Once per year

Coding

HCPCS Code	Description
G0102	Prostate cancer screening; digital rectal examination (DRE)
G0103	Prostate cancer screening; prostate specific antigen test (PSA)

- ICD-10 diagnosis coding: Z12.5
  - Additional ICD-10 codes may apply. See the CMS ICD-10 webpage for individual change requests and the specific ICD-10-CM codes Medicare covers for this service

Colorectal Cancer Screening

Did You Know?

- Colorectal cancer
  - Patients rarely display any symptoms, cancer can progress unnoticed and untreated
  - Most commonly found in individuals age 50 or older
- Colorectal screenings
  - Performed to diagnose or determine beneficiary's risk for developing colon cancer
  - May consist of several different screening test/procedures to test for polyps or colorectal cancer

High Risk Factors

- High-risk factors associated with colorectal cancer
  - Close relative (sibling, parent, or child) who has had colorectal cancer or adenomatous polyp
  - Family history of familial adenomatous polyposis
  - Family history of hereditary nonpolyposis colorectal cancer
  - Personal history of adenomatous polyps
  - Personal history of colorectal cancer
  - Inflammatory bowel disease, including Crohn's disease and ulcerative colitis
    - 42 CFR Section 410.37(a)(3)

Coding

CPT/HCPCS Codes	Description
G0104*	Flexible sigmoidoscopy
G0105*	Colonoscopy on individual at high risk
G0106	Screening sigmoidoscopy, barium enema – alternative to G0104
G0120	Screening colonoscopy, barium enema – alternative to G0105
G0121*	Colonoscopy on individual not at high risk
G0327	Colorectal cancer screening; blood-based biomarker
G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous

* Indicates can be billed with a prolonged preventive services add-on

Coding

CPT/HCPCS Codes	Description
81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 & BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)

Diagnosis Codes

- Z86.004
  - See CMS ICD-10 webpage for individual CRs and coding translations
- For Multitarget Stool DNA and blood-based biomarker tests
  - Z12.11 and Z12.12
- Additional codes may apply. See individual Change Requests on CMS ICD-10 webpage

Patients Not Meeting High Risk Criteria

Service	Timeframe
Multitarget sDNA test	Once every 3 years
Screening FOBT	Once every 12 months
Screening Flexible Sigmoidoscopy	Once every 48 months **
Screening Colonoscopy	Once every 120 months or 48 months after a previous sigmoidoscopy
Screening Barium Enema (when used instead of a flexible sigmoidoscopy or colonoscopy)	Once every 48 months

**Unless the patient doesn't meet the criteria for high risk of developing colorectal cancer and the patient had a screening colonoscopy within the preceding ten years. If so, Medicare may cover a screening flexible sigmoidoscopy only after at least 119 months passed following the month the patient got the screening colonoscopy.

Patients Meeting High Risk Criteria

Service	Timeframe
Screening FOBT	Once every 12 month
Screening Flexible sigmoidoscopy	Once every 48 months
Screening Colonoscopy	Once every 24 months **
Screening Barium Enema (when used instead of a flexible sigmoidoscopy or colonoscopy)	Once every 24 months

**Unless a screening flexible sigmoidoscopy was performed and then Medicare may cover a screening colonoscopy only after at least 47 months.

Coverage Criteria

- Multitarget sDNA Test
  - Patient who falls into all categories below
    - Age 50-85 years
    - Asymptomatic
    - At average risk of developing colorectal cancer

Coverage Criteria

- Screening colonoscopy, fecal occult blood test (FOBT), flexible sigmoidoscopy, barium enema
  - Patient who falls into one category below
    - Age 50 and older at normal risk of developing colorectal cancer
    - At high risk of developing colorectal cancer
  - **Note:** Coverage of screening colonoscopies has no age limitation
  - "High risk for developing colorectal cancer" is defined in 42 CFR Section 410.37(a)(3)

Deductible/Copay/Coinsurance

- Copayment/Coinsurance/Deductible waived for
  - 00812
  - 81528
  - 82270
  - G0104
  - G0105
  - G0121
  - G0327
  - G0328

Deductible/Copay/Coinsurance

- Copayment/Coinsurance applies
- Deductible waived
  - G0106
  - G0120
    - **Note:** No deductible applies for surgical procedures (CPT code range 10000–69999) on same date/encounter as screening colonoscopy, flexible sigmoidoscopy, or barium enema initiated a colorectal cancer screening services
    - Append modifier PT to CPT code in the 10000–69999 surgical range in this scenario

Colorectal Cancer Screening

- A special coinsurance rule will apply for procedures that are planned as colorectal cancer screening tests but become diagnostic
  - Beneficiary responsible for coinsurance for the diagnostic test in these cases
- Section 122 of the Consolidated Appropriations Act (CAA) will reduce over time the amount of coinsurance the beneficiary will be responsible for

Colorectal Cancer Screening

- Effective 1/1/2022
- CY 2022
  - Coinsurance 20%
- CY 2023 through CY 2026
  - Coinsurance 15%
- CY 2027 through CY 2029
  - Coinsurance 10%
- CY 2030
  - Coinsurance 0%

Colorectal Cancer Screening

- Reduction over time holds true regardless of the code that is billed for establishment of a diagnosis, for removal of tissue or other matter, or for another procedure that is furnished in connection with and in the same clinical encounter as the screening

Anesthesia, Screening – 00812

- CPT 00812 (anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy) in conjunction with a screening colonoscopy
  - Append modifier 33 to anesthesia code to waive copayment/coinsurance/deductible

Anesthesia, Diagnostic – 00811

- CPT 00811 (anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified) in conjunction with a diagnostic colonoscopy
  - Add PT modifier to indicate converted from screening to diagnostic
    - Waiver of deductible only

Moderate Sedation – G0500 or 99153

- Both coinsurance and deductible waived when provided with screening colonoscopy
  - Report with 33 modifier
- Only deductible waived when colonoscopy becomes diagnostic
  - Report with PT modifier

Incomplete Colonoscopy

- When covered colonoscopy attempted but not completed
  - Append modifier 53 to indicate procedure discontinued
- When covered colonoscopy next attempted and completed
  - Colonoscopy will be paid according to payment methodology for procedure for both screening and diagnostic colonoscopies
    - Coverage conditions must be met and frequency standards will be applied by CWF

References

BMM Resources

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 13, Section 140
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 80.5
- Update to Bone Mass Measurements (BMM) Code 77085 Deductible and Coinsurance
- Guide to Medicare Preventive Services

Colorectal Cancer Resources

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual, Chapter 18, Section 60*
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual, Chapter 15, Section 280.2*
- MLN Matters® *MM10075: Payment for Moderate Sedation Services Furnished with Colorectal Cancer Screening Tests*

Prostate Cancer Resources

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 50

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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