Overview
The following services are considered colorectal cancer screening services:

- Annual fecal occult blood tests (FOBTs);
- Flexible sigmoidoscopy;
- Screening colonoscopy for persons at average risk for colorectal cancer every 10 years,
- Screening colonoscopy for persons at high risk* for colorectal cancer every 2 years;
- Barium enema every 4 years as an alternative to flexible sigmoidoscopy, or
- Barium enema every 2 years as an alternative to colonoscopy for persons at high risk*;
- Cologuard™ - Multitarget Stool DNA (sDNA) Test (effective October 9, 2014)

*Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- 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; or
- A personal history of inflammatory bowel disease, Crohn’s Disease, and ulcerative colitis

It is not expected that these screening services are performed on patients that present with active gastrointestinal symptomatology.

Colorectal Cancer Screening Guidelines

<table>
<thead>
<tr>
<th>Colorectal Cancer Screening Test/Procedure</th>
<th>CPT/HCPCS Code</th>
<th>Colorectal Cancer Screening Test/Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Fecal-Occult Blood Test</td>
<td>82270, G0328</td>
<td>Once every 12 months for patients age 50 and older.</td>
</tr>
<tr>
<td>Screening Flexible Sigmoidoscopy</td>
<td>G0104</td>
<td>Once every 48 months for patients age 50 and older when performed by a doctor of medicine or osteopathy, or a physician assistant, nurse practitioner, or clinical nurse specialist.</td>
</tr>
<tr>
<td>Screening Colonoscopy - individual at high risk</td>
<td>G0105</td>
<td>Once every 24 months for patients at any age who are at high risk for colorectal cancer, when performed by a doctor of medicine or osteopathy.</td>
</tr>
</tbody>
</table>
# Colorectal Cancer Screening Guidelines

<table>
<thead>
<tr>
<th>Colorectal Cancer Screening Test/Procedure</th>
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</thead>
<tbody>
<tr>
<td>Screening Colonoscopy - individual not meeting criteria for high risk</td>
<td>G0121</td>
<td>Once every 10 years but not within 48 months of a screening sigmoidoscopy for patients at any age who are not at high risk, when performed by a doctor of medicine or osteopathy.</td>
</tr>
<tr>
<td>Screening Barium Enema, alternative to G0104 (screening sigmoidoscopy)*</td>
<td>G0106</td>
<td>Physicians may substitute a barium enema examination for flexible sigmoidoscopy every 4 years for patients age 50 and older.</td>
</tr>
<tr>
<td>Screening Barium Enema, alternative to G0105 (screening colonoscopy)*</td>
<td>G0120</td>
<td>Physicians may substitute a barium enema examination for colonoscopy every 2 years for high-risk patients.</td>
</tr>
<tr>
<td>Screening Barium Enema not performed as an alternative to G0105 or G0104.</td>
<td>G0122</td>
<td>This service is denied as noncovered, because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.</td>
</tr>
<tr>
<td>Multitarget Stool DNA (sDNA) Colorectal Cancer Screening Test - Cologuard™</td>
<td>G0464 (Effective 01/01/2015-12/31/2015), 81528 (Effective 01/01/2016)</td>
<td>Ages 50 to 85 years, once every 3 years; Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test), and, At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).</td>
</tr>
</tbody>
</table>

## Nationally Non-Covered Indications
All other indications for colorectal cancer screening not otherwise specified in the Act and regulations, or otherwise specified above remain nationally non-covered. Non-coverage specifically includes:
- All screening sDNA tests, effective April 28, 2008, through October 8, 2014. Effective for dates of service on or after October 9, 2014, all other screening sDNA tests not otherwise specified above remain nationally non-covered.
- Screening computed tomographic colonography (CTC), effective May 12, 2009.

## APPLICABLE CODES
The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00810</td>
<td>Anesthesia for lower intestinal endoscopic procedures introduced distal to duodenum (Expired 12/31/2017)</td>
</tr>
<tr>
<td>00811</td>
<td>Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified (Effective 01/01/2018)</td>
</tr>
<tr>
<td>00812</td>
<td>Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy (Effective 01/01/2018)</td>
</tr>
<tr>
<td>74263</td>
<td>Computed tomographic (CT) colonography, screening, including image postprocessing (Not covered)</td>
</tr>
</tbody>
</table>
### CPT Code | Description
---|---
81528 | Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result *(Effective 01/01/2016)*
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)

### HCPCS Code | Description
---|---
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
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 (Not covered)
G0328 | Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous determinations
G0464 | Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3) *(New Code Effective 01/01/2015-12/31/2015)*

### Modifier | Description
---|---
33 | Preventive services
53 | Discontinued procedure
PT | Colorectal cancer screening test; converted to diagnostic test or other procedure
QW | CLIA waived

### PURPOSE
The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:
- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

### REFERENCES

**CMS National Coverage Determinations (NCDs)**

NCD 210.3 Colorectal Cancer Screening Tests
Reference NCD: NCD 190.34 Fecal Occult Blood Test

**CMS Local Coverage Determinations (LCDs)**

<table>
<thead>
<tr>
<th>LCD</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>L36355 (Colorectal Cancer Screening) First Coast</strong></td>
<td>FL, PR, VI</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td><strong>L33283 (Computed Tomographic Colonography) First Coast</strong></td>
<td>FL, PR, VI</td>
<td>FL, PR, VI</td>
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</tbody>
</table>
## LCD

<table>
<thead>
<tr>
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<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>L33452 (Virtual Colonoscopy (CT Colonography)) Palmetto</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
</tr>
<tr>
<td>L33562 (Computed Tomographic (CT) Colonography for Diagnostic Uses) NGS</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
</tr>
<tr>
<td>L34055 (Virtual Colonoscopy (CT Colonography)) CGS</td>
<td>KY, OH</td>
<td>KY,OH</td>
</tr>
</tbody>
</table>

## CMS Articles

<table>
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<tr>
<th>Article</th>
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<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>A52378 (Colorectal Cancer Screening –Medical Policy Article) NGS</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
</tr>
<tr>
<td>A54885 (Computed Tomographic Colonography Coding Guidelines) First Coast</td>
<td>FL, VI, PR</td>
<td>FL, VI, PR</td>
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</tbody>
</table>

## CMS Benefit Policy Manual

Chapter 13; § 50.2 FQHC Services, § 210.1.4 Copayment and Deductible for Preventive Health Services
Chapter 15; § 280.2 Colorectal Cancer Screening
Chapter 16; § 90 Routine Services and Appliances

## CMS Claims Processing Manual

Chapter 18; § 60 Colorectal Cancer Screening
Chapter 19; § 80.5 Carrier-Screening and Preventive Services, § 100.13 FI-Other Screening and Preventive Services - Payment Policy

## CMS Transmittals

Transmittal 176. Change Request 8881, Dated 10/17/2014 (Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) and Screening Fecal-Occult Blood Tests (FOBT))
Transmittal 183. Change Request 9115, Dated 08/06/2015 (National Coverage Determination (NCD) for Screening for Colorectal Cancer Using Cologuard™ - A Multitarget Stool DNA Test)
Transmittal 1537, Change Request 9252, Dated 08/21/2015 (ICD-10 Conversion/Coding Infrastructure Revisions to National Coverage Determinations (NCDs)–3rd Maintenance CR)
Transmittal 1580, Change Request 9252, Dated 12/03/2015 (ICD-10 Conversion/Coding Infrastructure Revisions to National Coverage Determinations (NCDs)–3rd Maintenance CR)
Transmittal 1658, Change Request 9540, Dated 04/29/2016 (Coding Revisions to National Coverage Determinations) Transmittal 1665, Change Request 9631, Dated 05/13/2016 (Coding Revisions to National Coverage Determinations (NCDs)) Transmittal 1672, Change Request 9631, Dated 06/03/2016 (Coding Revisions to National Coverage Determinations (NCDs))
Transmittal 1755, Change Request 9861, Dated 11/18/2016 (ICD-10 Coding Revisions to National Coverage Determination (NCDs))
Transmittal 1792, Change Request 9861, Dated 02/03/2017 (ICD-10 Coding Revisions to National Coverage Determination (NCDs))
Transmittal 2033, Change Request 10473, Dated 02/16/2018 (ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs))
Transmittal 2039, Change Request 10473, Dated 02/28/2018 (ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs))
Transmittal 3096, Change Request 8881, Dated 10/17/2014 (Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) and Screening Fecal-Occult Blood Tests (FOBT))
Transmittal 3763, Change Request 10075, Dated 04/28/2017 (Payment for Moderate Sedation Services Furnished with Colorectal Cancer Screening Tests) Transmittal 3848, Change Request 10199, Dated 08/25/2017 (Updates to Pub. 100-04, Chapter 18 Preventive and Screening Services and Chapter 32 Billing Requirements for Special Services and Publication 100-03, Chapter 1 Coverage Determinations Part 4)
Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2019</td>
<td>• Reorganized policy template; relocated Terms and Conditions and Purpose section</td>
</tr>
<tr>
<td>10/10/2018</td>
<td>• Annual review</td>
</tr>
</tbody>
</table>

TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of

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*Member specific benefit plan document refers to the specific plan document(s) that provide the details of the services covered and any limitations or exclusions for the member's specific Medicare Advantage Plan.
You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.