CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13248	**Date: May 29, 2025**
	Change Request 14031

SUBJECT: Omnibus Change Request (CR) Covering Updates for the Medicare Physician Fee Schedule (MPFS) Rule 2025: (1) Updates to Colorectal Cancer Screening and Hepatitis B Vaccine Policies

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make contractors aware of policy updates for Colorectal Cancer Screening and Hepatitis B resulting from changes specified in the Calendar Year (CY) 2025 Physician Fee Schedule (PFS) Final Rule (89 FR 97710), published in the Federal Register (FR) on December 9, 2024.

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 6, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/10/10.1.3/Hepatitis B Vaccine
R	18/10/10.2.5/Claims Submitted to MACs (Part B)
R	18/60/Colorectal Cancer Screening
R	18/60/60.1/Payment
R	18/60/60.1.1/Deductible and Coinsurance
R	18/60/60.2/HCPCS Codes, Frequency Requirements, and Age Requirements
R	18/60/60.2.1/Common Working Files (CWF) Edits
R	18/60/60.5/Noncovered Services
R	18/60/60.6/Billing Requirements for Claims Submitted to A/B Macs (A)
R	18/60/60.7/Medicare Summary Notice (MSN) Messages
R	18/60/60.8/Remittance Advice Codes
R	18/Table 1.2/Table of Preventive and Screening Services

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13248	Date: May 29, 2025	Change Request: 14031

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II. GENERAL INFORMATION

A. Background: On November 1, 2024, CMS issued a rule finalizing changes for Medicare payments for calendar year 2025 under the Physician Fee Schedule (PFS) and other Medicare Part B policies. The final rule was published in the Federal Register on December 9, 2024, (89 FR 97710), and was effective January 1, 2025. The final rule is available at: https://www.federalregister.gov/documents/2024/12/09/2024-25382/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other

This Change Request (CR) includes policy changes finalized in this rule, related to coverage and payment of Colorectal Cancer Screening (CRC).

Colorectal Cancer Screening (CRC):

Medicare coverage of CRC screening tests under Part B are described in statutes (sections 1861(s)(2)(R), 1861(pp), 1862(a)(1)(H) and 1834(d) of the Social Security Act (the Act)), regulation (42 Code of Federal Regulation (CFR) 410.37), and National Coverage Determination (NCD Section 210.3, Publication 100-03). The statute and regulations expressly authorize the Secretary to add other tests and procedures (and make modifications to tests and procedures) for CRC screening with such frequency and payment limits the Secretary finds appropriate based on consultation with appropriate organizations. The current covered CRC screening tests under Medicare include barium enema procedures, fecal occult blood tests, flexible sigmoidoscopies, colonoscopies, multi-target stool DNA tests, and certain blood-based biomarker tests.

B. Policy: Updates to CRC Screening: Effective January 1, 2025, CMS is removing coverage of barium enema as a method of screening because this service is rarely used in Medicare and is no longer recommended as an evidence-based screening method. CMS is also expanding coverage for CRC screening to include Computed Tomography Colonography (CTC). Finally, CMS is adding Medicare covered blood-based biomarker CRC screening tests as part of the continuum of screening. Like stool-based CRC screening tests, which are already in the definition of a "complete CRC screening," a blood-based biomarker test with a positive result will lead to a follow-on screening colonoscopy (with no beneficiary cost-sharing). We are also revising the regulation text to clarify that CRC screening frequency limitations do not apply to the follow-on screening colonoscopy in the context of "complete CRC screening." These actions will promote access and remove barriers for much needed cancer prevention and early detection within rural communities

and communities of color that are especially impacted by the incidence of CRC. To read the discussions of the changes just described, see Section III.K Modifications to Coverage of Colorectal Cancer Screening (preamble pages 98313 – 98320 and changes to 42 C.F.R 410.37 on pages 98555-98556), and related payment changes in section III.E. Valuation of Specific Codes (preamble subsection 7 on pages 97772 – 97774 and subsection 15 on page 97788).

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14031 - 04.1	Effective for claims with Dates of Service (DOS) on or after January 1, 2025, contractors shall recognize CT Colonography (CTC) (Healthcare Common Procedure Coding System (HCPCS) 74263) as a covered service. NOTE: Refer to Pub. 100-02, chapter 15, section 280.2 for coverage policy; and Pub. 100-04, chapter 18, section 60 for claims processing instructions.	X	X							
14031 - 04.1.1	Effective for claims with DOS on or after January 1, 2025, contractors shall not apply beneficiary coinsurance and deductibles to line-items on claims containing HCPCS 74263.	X	X			X				
14031 - 04.2	Effective for claims with DOS on or after October 3, 2024, contractors shall recognize Cologuard Plus (HCPCS 0464U) as a covered service. NOTE: Refer to Pub. 100-02, chapter 15, section 280.2 for coverage policy; and Pub. 100-04, chapter 18, section 60 for claims processing	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	instructions.									
14031 - 04.2.1	Effective for claims with DOS on or after October 3, 2024, contractors shall not apply beneficiary coinsurance and deductibles to line-items on claims containing HCPCS 0464U. Note: For institutional claims, since this HCPCS code is billed under the clinical laboratory fee schedule, the system shall automatically suppress coinsurance and deductible.	X	X			X				
14031 - 04.3	Effective for claims with DOS on or after January 1, 2025, contractors shall deny line-items on claims containing HCPCS 74263 when reported: • more than once in a 5-year period (at least 59 months have passed following the month in which the last screening CTC was performed) for not at high-risk beneficiaries, • more than once in a 4-year period (at least 47 months have passed following the month in which the last flexible sigmoidoscopy or screening colonoscopy was performed) for not at	X	X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	high-risk beneficiaries, • more than once in a 2-year period (at least 23 months have passed following the month in which the last screening CTC or the last screening colonoscopy was performed for high-risk beneficiaries.									
14031 - 04.3.1	When denying a line-item on a claim per requirement 14031-04.3, contractors shall use the following messages: Claim Adjustment Reason Code (CARC) 119: "Benefit maximum for this time period or occurrence has been reached." Remittance Advice Remark Code (RARC) N640 – Exceeds number/frequency approved/allowed within time period. Medicare Summary Notice (MSN)15.6 – The information provided does not support the need for this many services or items within this period of time.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Spanish Version – La informacion proporcionada no confirma la necesidad de estos servicios o articulos en este period de tiempo. Group Code: CO (Contractual Obligation)									
14031 - 04.4	Effective for claims with DOS on or after October 3, 2024, contractors shall deny line-items on claims containing HCPCS 0464U when reported: more than once in a 3-year period (at least 35 months have passed following the month in which the last Cologuard Plus screening test was performed)	X	X			X			X	CVM
14031 - 04.4.1	When denying a line-item on a claim per requirement 14031.4, contractors shall use the following messages: CARC 119: “Benefit maximum for this time period or occurrence has been reached.” RARC N386: “This decision was based on a National Coverage Determination (NCD). An NCD provides a	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp If you do not have web access, you may contact the contractor to request a copy of the NCD." Group Code: CO (Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800- MEDICARE (1-800-633-4227) for a copy of the LCD". Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227). MSN 15.20: "The following policies NCD 210.3 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD									

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	210.3 fueron utilizadas cuando se tomó esta decisión." NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.									
14031 - 04.5	Effective for claims with DOS on or after October 3, 2024, contractors shall deny line-items on claims containing Cologuard Plus, HCPCS 0464U, when the beneficiary is not between ages 45 and 85. NOTE: Contractors shall use current messages for Cologuard (HCPCS code 81528) when denying claims based on age requirements. FISS shall update the Standard Narrative for the existing CWF reason code(s) being modified.	X	X			X			X	
14031 - 04.5.1	CWF shall create a one-time utility to capture all beneficiaries that have a CT Colonography (CTC) HCPCS 74263 from January 1, 2025, and/or Cologuard Plus HCPCS 0464U from October 3, 2024, to the implementation date of this CR.								X	
14031 - 04.5.2	CWF shall send a one-time refresh to MBD/NGD/HETS to capture all beneficiaries that have CT Colonography (CTC) HCPCS 74263 from January 1, 2025, and/or Cologuard Plus HCPCS 0464U from								X	HETS, MBD, NGD

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	October 3, 2024, to the implementation date of this CR.									
14031 - 04.6	Effective for claims with DOS on or after January 1, 2025, contractors shall deny line-items on claims containing a CTC screening test, HCPCS 74263, when the beneficiary's age is not 45 or older. Note: FISS shall update the Standard Narrative for the existing CWF reason code(s) being modified.	X	X			X			X	CVM
14031 - 04.6.1	When denying a line-item on a claim per business requirement 14031-04.6, contractors shall use the following messages: CARC 6 – The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF), if present. RARC N129 – Not eligible due to patient's age. MSN 15.4 – The information provided does not support the need for this service or item. Spanish Version – La informacion proporcionada no confirma la necesidad para este servicio o articulo. Group Code – CO or PR (Patient Responsibility)	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the item).									
14031 - 04.7	Effective for claims with DOS on or after January 1, 2025, contractors shall deny line-items on claims reporting CTC, HCPCS 74263 without **high risk ICD-10 diagnosis from List 1 of the coding spreadsheet for NCD 210.3.**	X	X			X				
14031 - 04.7.1	When denying claims based on diagnosis requirements, contractors shall use the following messages: Claim Adjustment Reason Code (CARC) 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC) MA63 – Missing/incomplete/invalid principal diagnosis. MSN 15.4 – The information provided does not support the need for this service or item. Spanish Version – La informacion proporcionada no confirma la necesidad para este servicio o articulo. Group Code - CO (Contractual Obligation) or PR (Patient Responsibility) dependent	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the item).									
14031 - 04.8	Effective for claims with DOS on or after October 3, 2024, contractors shall deny line-items on claims reporting Cologuard Plus, HCPCS 0464U, without ICD-10 diagnosis Z12.12 or Z12.11 NOTE: This edit should be overridable.	X	X			X				
14031 - 04.8.1	When denying claims based on diagnosis requirements, contractors shall use the following messages: CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at: www.cms.gov/mcd/search.asp . If you do not have web access, you may contact the contractor to request a copy of the NCD. (Part A only) MSN 15.19 - "We used a Local Coverage Determination (LCD) to	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor." Spanish Version -Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su medico MSN 15.20 - "The following polices were used when we made this decision: NCD 210.3." NOTE: Due to a system requirement, the Fiscal Intermediary Shared System (FISS) has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN. Group Code - CO or PR dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the item).									
14031 - 04.9	Effective for claims with DOS on or after January 1, 2025,	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	contractors shall allow CTC, HCPCS 74263, on the following Type of Bills (TOBs): • 012X, • 013X, • 085X									
14031 - 04.9.1	Contractors shall Return to Provider (RTP) any claim submitted for CTC, HCPCS 74263, when the TOB is not 012X, 013X, or 085X.	X				X				
14031 - 04.9.2	Contractors shall pay for CTC, HCPCS 74263, on institutional claims TOBs 012X, 013X, based on OPPS and TOB 085X with revenue code other than 096x, 097x, or 098x based on reasonable cost. TOB 085X claims with revenue code 096x, 097x, or 098x are paid based on MPFS (115% of the lesser of the fee schedule amount and submitted charge).	X				X				
14031 - 04.10	Effective for claims with DOS on or after October 3, 2024, contractors shall allow Cologuard Plus, HCPCS 0464U, on the following TOBs: • 012X, 013X, 014X and 085X	X				X				
14031 - 04.10.1	Contractors shall RTP any claim submitted for Cologuard Plus, HCPCS 0464U, when the TOB is not 012X, 013X,	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	014X, or 085X.									
14031 - 04.10.2	Contractors shall pay for Cologuard Plus, HCPCS 0464U, on institutional claims in hospital outpatient departments (TOB 12X and 13X) and hospital non-patient laboratories (14X) based on the clinical laboratory fee schedule. Payment for Critical Access Hospitals (CAHs, TOB 85X) is based on reasonable cost.	X				X				
14031 - 04.11	Effective for claims with DOS on or after January 1, 2025 for CTC (HCPCS 74263) and October 3, 2024, for Cologuard Plus (HCPCS 0464U), contractors shall calculate a next eligible date for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status • Beneficiary claims history • Utilization rules NOTE: The calculation for the next eligible date for CTC and Cologuard Plus shall parallel claims processing. The contractor shall display the next eligible dates on the PRVN screen.								X	CVM, MBD, NGD
14031 - 04.11.1	Contractors shall display the next eligible dates on all CWF provider query screens (HUQA).					X	X		X	MBD, NGD
14031 - 04.11.2	When there is no ‘next eligible date’ the contractor shall								X	MBD, NGD

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	display information in the date field to indicate why there is no 'next eligible date.'									
14031 - 04.11.3	The contractor shall ensure that any change to beneficiary master data or claims data that would result in a change to any 'next eligible' date should result in an update to the beneficiary's 'next eligible date.'								X	HETS, MBD, NGD
14031 - 04.12	CWF shall modify the HICR transaction HCSR to include the HCPC code 74263 and 0464U.								X	
14031 - 04.13	The contractor shall update the Multi-Carrier System Desktop Tool (MCSDT) to display HCPCS 74263 and 0464U sessions on a separate screen and in a format equivalent to the CWF HIMR screen.		X				X			
14031 - 04.14	Effective for DOS on or after January 1, 2025, contractors shall be aware that HCPCS G0106 and G0120 are no longer covered.	X	X			X			X	CVM
14031 - 04.15	Contractors shall not search for claims containing HCPCS 74263 (with DOS on or after January 1, 2025) and 0464U (with DOS on or after October 3, 2024), but contractors may adjust claims that are brought to their attention.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to

relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

60 - Colorectal Cancer Screening

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

See the Medicare Benefit Policy Manual, Chapter 15, and the Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Section 210.3 for Medicare Part B coverage requirements and effective dates of colorectal cancer screening services.

Effective for services furnished on or after January 1, 1998, payment may be made for colorectal cancer screening for the early detection of cancer. For screening colonoscopy services (one of the types of services included in this benefit) prior to July 2001, coverage was limited to high-risk individuals. For services July 1, 2001, and later, screening colonoscopies are covered for individuals not at high risk.

The following services are considered colorectal cancer screening services:

- *Colonoscopy;*
- *Computed Tomography (CT) Colonography;*
- *Flexible sigmoidoscopy;*
- *Fecal-occult blood test (FOBT), 1-3 simultaneous determinations (guaiac-based);*
- *Multi-target Stool DNA (sDNA) test; and*
- *Blood-based Biomarker test.*

Effective for services on or after January 1, 2004, payment may be made for the following colorectal cancer screening service as an alternative for the guaiac-based FOBT, 1-3 simultaneous determinations:

- FOBT, immunoassay, 1-3 simultaneous determinations

Effective for services on or after October 9, 2014, payment may be made for colorectal cancer screening using the Cologuard™ multi-target sDNA test:

- HCPCS G0464 (Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3).

  Note: HCPCS code G0464 expired on December 31, 2015, and has been replaced in the 2016 CLFS with CPT code 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 January 2, 2016**.**

Effective for services on or after January 19, 2021, payment may be made for colorectal cancer using Blood-based DNA Testing:

- Blood-based Biomarker Test, HCPCS G0327, effective July 1, 2021

Effective for services on or after October 3, 2024, payment may be made for Cologuard Plus (HCPCS code 0464U).

Effective for services on or after January 1, 2025, payment may be made for colorectal cancer screening using Computed Tomography (CT) Colonography (CPT code 74263).

Effective for services or after January 1, 2025, Barium enema (HCPCS G0106 and G0120) is no longer a covered service.

60.1 – Payment

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

Payment is under the MPFS except as follows:

- FOBTs [CPT 82270* (HCPCS G0107*) and HCPCS G0328] are paid under the CLFS except reasonable cost is paid to all non-outpatient prospective payment system (OPPS) hospitals, including Critical Access Hospitals (CAHs), but not Indian Health Service (IHS) hospitals billing on type of bill (TOB) 83X. IHS hospitals billing on TOB 83X are paid the Ambulatory Surgery Center (ASC) payment amount. Other IHS hospitals (billing on TOB 13X) are paid the Office of Management and Budget (OMB)-approved all-inclusive rate (AIR), or the facility specific per visit amount as applicable. Deductible and coinsurance do not apply for these tests. See section A below for payment to Maryland waiver hospitals on TOB 13X. Payment to all hospitals for non-patient laboratory specimens on TOB 14X will be based on the CLFS, including CAHs and Maryland waiver hospitals.

- For claims with dates of service on or after January 1, 2015, through December 31, 2015, the Cologuard™ multi-target sDNA test (HCPCS G0464) is paid under the CLFS.

  Note: For claims with dates of service October 9, 2014, thru December 31, 2014, HCPCS code G0464 is paid under local contractor pricing.

- For claims with dates of service on or after January 1, 2016, CPT code 81528 replaces G0464 is paid under the CLFS.

- For claims with dates of service on or after January 19, 2021, Blood-based Biomarker test (HCPCS G0327) is paid under the CLFS

- Flexible sigmoidoscopy (code G0104) is paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs; or current payment methodologies for hospitals not subject to OPPS.

  - Colonoscopies (HCPCS G0105 and G0121) are paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs or current payment methodologies for hospitals not subject to OPPS. Also colonoscopies may be performed in an ASC and when done in an ASC, the ASC rate applies. The ASC rate is the same for diagnostic and screening colonoscopies. The ASC rate is paid to IHS hospitals when the service is billed on TOB 83X.

The following screening codes must be paid at rates consistent with the rates of the diagnostic codes indicated. Coinsurance and deductible apply to diagnostic codes.

HCPCS Screening Code	HCPCS Diagnostic Code
G0104	45330
G0105 and G0121	45378

A. Special Payment Instructions for TOB 13X Maryland Waiver Hospitals

For hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission, screening colorectal services HCPCS G0104, G0105, 82270* (G0107*) , G0121, G0328, G0464, and 81528 are paid according to the terms of the waiver, that is 94% of submitted charges minus any unmet existing deductible,

co-insurance and non-covered charges. Maryland Hospitals bill TOB 13X for outpatient colorectal cancer screenings.

B. Special Payment Instructions for Non-Patient Laboratory Specimen (TOB 14X) for All Hospitals

Payment for colorectal cancer screenings (CPT 82270* (HCPCS G0107*), HCPCS G0328, and G0464 (Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528) to a hospital for a non-patient laboratory specimen (TOB 14X), is the lesser of the actual charge, the fee schedule amount, or the National Limitation Amount (NLA), (including CAHs and Maryland Waiver hospitals). Part B deductible and coinsurance do not apply.

- ***NOTE:** For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 was discontinued and replaced with CPT 82270.

Effective for services or after January 1, 2025, Barium enema (HCPCS G0106 and G0120) is no longer a covered service.

60.1.1 – Deductible and Coinsurance

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

There is no deductible and no coinsurance or copayment for the FOBTs (HCPCS G0107, G0328), flexible sigmoidoscopies (G0104), colonoscopies on individuals at high risk (HCPCS G0105), or colonoscopies on individuals not meeting criteria of high risk (HCPCS G0121).

Effective for services on or after October 3, 2024, there is no deductible and no coinsurances of Cologuard Plus (HCPCS code 0464U).

Effective for services on or after January 1, 2025, there is no deductible and no coinsurance for Computed Tomography (CT) Colonography (CPT code 74263).

Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the -PT modifier; and the deductible is waived. Prior to January 1, 2022, when a screening colonoscopy became a diagnostic, the beneficiary was liable for the full applicable coinsurance. However, Section 122 of Division CC of the Consolidated Appropriations Act

(CAA) of 2021, Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests, amended section 1833(a) of the Social Security Act to offer a special coinsurance rule for screening flexible sigmoidoscopies and screening colonoscopies, regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure, that is furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test. Consequently, the applicable coinsurance in these specific scenarios will be gradually reduced until it is completely waived for dates of service on or after January 1, 2030. Specifically, for dates of service in CY 2023 through CY 2026, when the PT modifier is appended to at least one code on the claim to indicate that a screening colorectal cancer procedure, HCPCS G0104, G0105, or G0121, has become a diagnostic or therapeutic service, contractors shall continue to waive deductible and shall apply a reduced coinsurance of 15% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service in CY 2027 through CY 2029, contractors shall continue to waive deductible and shall apply a reduced coinsurance of 10% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service on or after January 1, 2030, contractors shall continue to waive deductible and shall waive coinsurance for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim.

Coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier -33. When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (G0500 or 99153) are reported with only the -PT modifier; only the deductible is waived.

Effective for claims with dates of service on and after October 9, 2014, deductible and coinsurance do not apply to the Cologuard™ multi-target sDNA screening test (HCPCS G0464). (Note: Beginning January 1, 2016, CPT code 81528 replaced G0464).

Effective for claims with dates of service on and after January 19, 2021, deductible and coinsurance do not apply to the Blood-based biomarker test (HCPCS G0327).

Effective for claims with dates of service on or after January 1, 2023, colorectal cancer screening tests include a screening colonoscopy (HCPCS codes G0105, G0121) that follows a non-invasive stool- based test (HCPCS codes 82270, G0328 and 81528). This scenario shall be identified by the furnishing practitioner by including the KX modifier on the screening colonoscopy claim. Deductible and coinsurance do not apply to the non-invasive stool-based tests nor the screening colonoscopy because both tests are specified preventive screening services.

NOTE: A 25% coinsurance applies for all colorectal cancer screening colonoscopies (HCPCS G0105 and G0121) performed in ASCs and non-OPPS hospitals effective for services performed on or after January 1, 2007. The 25% coinsurance was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

A 25% coinsurance also applies for colorectal cancer screening sigmoidoscopies (HCPCS G0104) performed in non-OPPS hospitals effective for services performed on or after January 1, 2007. Beginning January 1, 2008, colorectal cancer screening sigmoidoscopies (HCPCS G0104) are payable in ASCs, and a 25% coinsurance applies. The 25% coinsurance for colorectal cancer screening sigmoidoscopies was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

Effective for claims with dates of service on or after January 1, 2011, coinsurance and deductible do not apply to screening colonoscopies, screening sigmoidoscopies, and other specified colorectal cancer screening services.

60.2 - HCPCS Codes, Frequency Requirements, and Age Requirements

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

Effective for services furnished on or after January 1, 1998, the following codes are used for colorectal cancer screening services:

- CPT 82270* (HCPCS G0107*) - Colorectal cancer screening; fecal-occult blood tests, 1-3 simultaneous determinations;
- HCPCS G0104 - Colorectal cancer screening; flexible sigmoidoscopy;
- HCPCS G0105 - Colorectal cancer screening; colonoscopy on individual at high risk;

Effective for services furnished on or after July 1, 2001, the following codes are added for colorectal cancer screening services:

- HCPCS G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk.

Effective for services furnished on or after January 1, 2004, the following code is added for colorectal cancer screening services as an alternative to CPT 82270* (HCPCS G0107*):

- HCPCS G0328 - Colorectal cancer screening; immunoassay, fecal-occult blood test, 1-3 simultaneous determinations.

Effective for services furnished on or after October 9, 2014, the following code is added for colorectal cancer screening services:

- HCPCS G0464 - Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3). Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528.

Effective for services furnished on or after January 19, 2021, the following code is added for colorectal cancer *screening* services:

- HCPCS G0327 - Colorectal cancer screening; blood-based biomarker Colon ca scrn;bld-bsd biomrk

Effective for claims with dates of service on or after January 1, 2023, the frequency limitations for screening colonoscopy (HCPCS codes G0105, G0121) shall not apply when the screening colonoscopy follows a positive result from a non-invasive stool-based test (HCPCS codes 82270, G0328 and 81528). This scenario is identified when the furnishing practitioner submits the screening colonoscopy claim with the KX modifier. See 42 CFR 410.37(k).

***NOTE**: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 is discontinued and replaced with CPT 82270.

G0104 – Colorectal Cancer Screening; Flexible Sigmoidoscopy

Screening flexible sigmoidoscopies (HCPCS G0104) may be paid for beneficiaries who have attained age 50, when performed by a doctor of medicine or osteopathy at the frequencies noted below.

For claims with dates of service on or after January 1, 2002, A/B MACs (A) and (B) pay for screening flexible sigmoidoscopies (HCPCS G0104) for beneficiaries who have attained age 50 when these services were performed by a doctor of medicine or osteopathy, or by a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) (as defined in §1861(aa)(5) of the Social Security Act (the Act) and in the Code of Federal Regulations (CFR) at 42 CFR 410.74, 410.75, and 410.76) at the frequencies noted above. For claims with dates of service prior to January 1, 2002, Medicare Administrative Contractors (MACs) pay for these services under the conditions noted only when a doctor of medicine or osteopathy performs them.

For services furnished from January 1, 1998, through June 30, 2001, inclusive:

- Once every 48 months (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed).

For services furnished on or after July 1, 2001:

- Once every 48 months as calculated above **unless** the beneficiary does not meet the criteria for high risk of developing colorectal cancer (refer to §60.3 of this chapter) **and** he/she has had a screening colonoscopy (HCPCS G0121) within the preceding 10 years.

If such a beneficiary has had a screening colonoscopy within the preceding 10 years, then he or she can have covered a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that he/she received the screening colonoscopy (HCPCS G0121).

Effective for claims with dates of service on or after January 1, 2023, the minimum age for screening flexible sigmoidoscopy is reduced to 45 years and older.

NOTE: If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth; the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal along with modifier -PT should be billed and paid rather than HCPCS G0104.

HCPCS G0105 – Colorectal Cancer; Colonoscopy on Individual at High Risk

Screening colonoscopies (HCPCS code G0105) may be paid when performed by a doctor of medicine or osteopathy at a frequency of once every 24 months for beneficiaries at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered HCPCS G0105 screening colonoscopy was performed). Refer to §60.3 of this chapter for the criteria to use in determining whether or not an individual is at high risk for developing colorectal cancer.

NOTE: If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal along with modifier -PT should be billed and paid rather than HCPCS G0105.

A. Colonoscopy Cannot be Completed Because of Extenuating Circumstances

1. A/B MACs (A)

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. However, the frequency standards associated with screening colonoscopies will not be applied by the Common Working File (CWF). 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, and the frequency standards will be applied by CWF. This policy is applied to both screening and diagnostic colonoscopies. When submitting a facility claim for the interrupted colonoscopy, providers are to suffix the colonoscopy.

Use of HCPCS codes with a modifier of -73 or -74 is appropriate to indicate that the procedure was interrupted. Payment for covered incomplete screening colonoscopies shall be consistent with payment methodologies currently in place for complete screening colonoscopies, including those contained in 42 CFR 419.44(b). In situations where a CAH has elected payment Method II for CAH patients, payment shall be consistent with payment methodologies currently in place as outlined in chapter 3 of this manual. As such, instruct CAHs that elect Method II payment to use modifier -53 to identify an incomplete screening colonoscopy (physician professional service(s) billed in 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 -73 or -74 modifier as appropriate.

Note that Medicare would expect the provider to maintain adequate information in the patient's medical record in case it is needed by the A/B MAC (A) to document the incomplete procedure.

2. A/B MACs (B)

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances (see chapter 12, section 30.1), Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes. The MPFS database has specific values for codes 44388-53, 45378-53, G0105-53 and G0121-53. 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. 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 submitting a claim for the facility fee associated with this procedure, ASCs) are to suffix the colonoscopy code with modifier -73 or -74 as appropriate. Payment for covered screening colonoscopies, including that for the associated ASC facility fee when applicable, shall be consistent with payment for diagnostic colonoscopies, whether the procedure is complete or incomplete.

Note that Medicare would expect the provider to maintain adequate information in the patient's medical record in case it is needed by the A/B MAC (B) to document the incomplete procedure.

HCPCS G0106 – Colorectal Cancer Screening; Barium Enema; as an Alternative to HCPCS G0104, Screening Sigmoidoscopy

Effective January 1, 2025, Barium Enema (HCPCS G0106 and G0120) is no longer covered by Medicare.

CPT 82270* (HCPCS G0107*) **– Colorectal Cancer Screening; FOBT, 1-3 Simultaneous Determinations**

Effective for services furnished on or after January 1, 1998, screening FOBT (code 82270* (HCPCS G0107*) may be paid for beneficiaries who have attained age 50, and at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed). This screening FOBT means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. This screening requires a written order from the beneficiary's attending physician, or effective for dates of service on or after January 27, 2014, the beneficiary's attending physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) 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.)

Effective for services furnished on or after January 1, 2004, payment may be made for an immunoassay-based FOBT (HCPCS G0328, described below) as an alternative to the guaiac-based FOBT, CPT 82270* (HCPCS G0107*). Medicare will pay for only one covered FOBT per year, either CPT 82270* (HCPCS G0107*) or HCPCS G0328, but not both.

***NOTE**: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 is discontinued and replaced with CPT 82270.

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; FOBT, 1-3 Simultaneous Determinations is reduced to 45 years and older.

HCPCS G0328 – Colorectal Cancer Screening; Immunoassay, FOBT, 1-3 Simultaneous Determinations

Effective for services furnished on or after January 1, 2004, screening FOBT, (HCPCS G0328) may be paid as an alternative to CPT 82270* (HCPCS G0107*) for beneficiaries who have attained age 50. Medicare will pay for a covered FOBT (either CPT 82270* (HCPCS G0107*) or HCPCS G0328, but not both) at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed).

Screening FOBT, immunoassay, includes the use of a spatula to collect the appropriate number of samples or the use of a special brush for the collection of samples, as determined by the individual manufacturer's instructions. This screening requires a written order from the beneficiary's attending physician, or effective for claims with dates of service on or after January 27, 2014, the beneficiary's attending PA, NP, or CNS. (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) 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.)

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; Immunoassay, FOBT, 1-3 Simultaneous Determinations is reduced to 45 years and older.

HCPCS G0120 – Colorectal Cancer Screening; Barium Enema; as an Alternative to HCPCS G0105, Screening Colonoscopy

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; Barium Enema; as an Alternative to Screening Colonoscopy is reduced to 45 years and older.

HCPCS G0121 – Colorectal Cancer Screening; Colonoscopy on Individual Not Meeting Criteria for High Risk - Applicable On and After July 1, 2001

Effective for services furnished on or after July 1, 2001, screening colonoscopies (HCPCS G0121) performed on individuals not meeting the criteria for being at high risk for developing colorectal cancer (refer to §60.3 of this chapter) may be paid under the following conditions:

- At a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered HCPCS G0121 screening colonoscopy was performed.)

- If the individual would otherwise qualify to have covered a HCPCS G0121 screening colonoscopy based on the above **but** has had a covered screening flexible sigmoidoscopy (HCPCS G0104), then he or she may have covered a HCPCS G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered HCPCS G0104 flexible sigmoidoscopy was performed.

NOTE: If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal along with modifier -PT should be billed and paid rather than HCPCS G0121.

HCPCS G0464 (Replaced with CPT 81528) - Multitarget sDNA Colorectal Cancer Screening Test - Cologuard™

Effective for dates of service on or after October 9, 2014, colorectal cancer screening using the Cologuard™ multi-target sDNA test (G0464/81528) is covered once every 3 years for Medicare beneficiaries that meet all of the following criteria:

- Ages 50 to 85 years,
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac FOBT 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 cancer adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

Effective for claims with dates of service on or after October 9, 2014, providers shall report at least ONE of the following diagnosis codes when submitting claims for the Cologuard™ multi-target sDNA test:

Z12.11 Encounter for screening for malignant neoplasm of colon, OR, Z12.12

Encounter for screening for malignant neoplasm of rectum

NOTE: Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Multitarget sDNA Colorectal Cancer Screening Test - Cologuard™ is reduced to 45 years and older.

HCPCS 0464U Cologuard Plus Colorectal Cancer Screening Test

Effective for dates of service on or after October 3, 2024, colorectal cancer screening using the Cologuard Plus Colorectal Cancer Screening test (0464U) is covered once every 3 years for Medicare beneficiaries that meet all of the following criteria:

- *Ages 45 to 85 years,*
- *Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac FOBT 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 cancer adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).*

Effective for claims with dates of service on or after January 1, 2025, providers shall report at least ONE of the following diagnosis codes when submitting claims for the Cologuard Plus

Z12.11 Encounter for screening for malignant neoplasm of colon, OR, Z12.12

Encounter for screening for malignant neoplasm of rectum

NOTE: A follow-on screening colonoscopy to a Cologuard Plus procedure is

considered part of a "complete CRC Screening" with no beneficiary cost sharing.

HCPCS G0327- Colorectal Cancer Screening - Blood-based Biomarker Tests

Blood-based DNA testing detects molecular markers of altered DNA that are contained in the cells shed into the lumen of the large bowel by colorectal cancer and pre-malignant colorectal epithelial neoplasia.

Effective for dates of service on or after January 19, 2021, a blood-based biomarker test is covered as an appropriate colorectal cancer screening test once every 3 years for Medicare beneficiaries when performed in a CLIA-certified laboratory, when ordered by a treating physician and when all of the following requirements are met:

The patient is:

- age 50-85 years, and,

- asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac FOBT 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 cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

The blood-based biomarker screening test must have all of the following:

- FDA market authorization with an indication for colorectal cancer screening; and,

- proven test performance characteristics for a blood-based screening test with both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in the detection of colorectal cancer compared to the recognized standard (accepted as colonoscopy at this time), as minimal threshold levels, based on the pivotal studies included in the FDA labeling.

Effective for claims with dates of service on or after January 19, 2021, providers shall report at least ONE of the following diagnosis codes when submitting claims for the Blood-based Biomarker test HCPCS G0327:

Z12.11 Encounter for screening for malignant neoplasm of colon, OR, Z12.12

Encounter for screening for malignant neoplasm of rectum

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening - Blood-based Biomarker Tests is reduced to 45 years and older.

HCPCS 74263 – CT Colonography

Effective for dates of service on or after January 1, 2025, CT Colonography is covered as an appropriate colorectal cancer screening procedure, when ordered by a treating physician and when all of the following requirements are met:

The patient is:

- *age 45 or older and,*

•asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac FOBT 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 cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer),

And:
•once in a 5-year period (at least 59 months have passed following the month in which the last screening computed tomography colonography was performed) for not at high-risk beneficiaries,

•once in a 4-year period (at least 47 months have passed following the month in which the last flexible sigmoidoscopy or screening colonoscopy was performed) for not at high-risk beneficiaries'
•once in a 2-year period (at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed for high-risk beneficiaries
And:
At least one of the high risk ICD-10 diagnosis codes from List 1 of the coding spreadsheet for NCD 210.3 is reported on the claim.

60.2.1 - Common Working Files (CWF) Edits

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

Effective for dates of service January 1, 1998, and later, CWF will edit all colorectal screening claims for age and frequency standards. The CWF will also edit A/B MAC (A) claims for valid procedure codes (HCPCS G0104, G0105, CPT 82270* (HCPCS G0107*), G0121, G0122, G0328, G0327, and CPT 81528 ** (HCPCS G0464**). The CWF currently edits for valid HCPCS codes for A/B/MACs (B). (See §60.6 of this chapter for TOBs.) *Effective 01/01/2025, CWF will edit procedure code 74263 for age and frequency standards.*

***NOTE**: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 is discontinued and replaced with CPT 82270.

** Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528.

60.5 - Noncovered Services

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

The following non-covered HCPCS codes are used to allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes for the dates of service indicated:

A. From January 1, 1998, through June 30, 2001, Inclusive

Code G0121 (colorectal cancer; colonoscopy on an individual not meeting criteria for high risk) should be used when this procedure is performed on a beneficiary who does **not** meet the criteria for high risk. This service should be denied as non-covered because it fails to meet the requirements of the benefit for these dates of service. The beneficiary is liable for payment. Note that this code is a covered service for dates of service on or after July 1, 2001.

B. On or After January 1, 1998

Code G0122 (colorectal cancer; 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 should be denied as non-covered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

C. On or after January 1, 2025

Codes G0106 and G0120 (colorectal cancer; barium enema) are no longer covered. The beneficiary is liable for payment.

60.6 - Billing Requirements for Claims Submitted to A/B MACs (A)

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

Follow the general bill review instructions in chapter 25. Hospitals use the ASC X12 837 institutional claim format to bill the A/B MAC (A) or the hardcopy Form CMS-1450 (UB-04). Hospitals bill revenue codes and HCPCS codes as follows:

Screening Tests/Procedures	**Revenue Codes**	**HCPCS Codes**	**TOBs**
FOBT	030X	82270*** (G0107***), G0328	12X, 13X, 14X**, 22X, 23X, 83X, 85X
Flexible Sigmoidoscopy	*	G0104	12X, 13X, 22X, 23X, 85X****
Colonoscopy-high risk	*	G0105, G0121	12X, 13X, 22X, 23X, 85X****
Multitarget sDNA - Cologuard™	030X	(G0464*****), 81528*****	13X, 14X** 85X
Cologuard Plus	*030X*	*(0464U)*	*12X, 13X, 14X** 85X*
Blood-based Biomarker	030X	(G0327)	13X, 14X** 85X
CT Colonography	*030X*	*74263*	12X, 13X 85X

* The appropriate revenue code when reporting any other surgical procedure.

** 14X is only applicable for non-patient laboratory specimens.

*** For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, HCPCS G0107, was discontinued and replaced with CPT 82270.

**** CAHs that elect Method II bill revenue code 096X, 097X, and/or 098X for professional services and 075X (or other appropriate revenue code) for the technical or facility component. *Effective January 1, 2025, Barium enema (HCPCS G0106 and G0120) is no longer covered by Medicare.*

***** Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528

Special Billing Instructions for Hospital Inpatients

When these tests/procedures are provided to inpatients of a hospital or when Part A benefits have been exhausted, they are covered under this benefit. However, the provider bills on TOB 12X using the discharge date of the hospital stay to avoid editing in CWF as a result of the hospital bundling rules.

60.7 - Medicare Summary Notice (MSN) Messages

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

The following Medicare Summary Notice (MSN) messages are used (See Chapter 21 for the Spanish versions of these messages):

A. If a claim for a screening FOBT, a screening flexible sigmoidoscopy, is being denied because of the age of the beneficiary, use:

18.29 - This service is not covered for people under 45 years of age.

Spanish Version- “Este servicio no está cubierto para las personas menores de 45 años.”

B. If the claim for a screening FOBT, a screening colonoscopy, a screening flexible sigmoidoscopy, is being denied because the time period between the same test or procedure has not passed, use:

18.14 - Service is being denied because it has not been (12, 24, 48, 120) months since your last (test/procedure) of this kind.

C. If the claim is being denied for a screening colonoscopy because the beneficiary is not at a high risk, use:

18.15 - Medicare covers this procedure only for people considered to be at a high risk for colorectal cancer.

D. If the claim is being denied because payment has already been made for a screening FOBT (CPT 82270* (HCPCS G0107*) or HCPCS G0328), flexible sigmoidoscopy (HCPCS G0104), screening colonoscopy (HCPCS G0105) use:

18.16 - This service is denied because payment has already been made for a similar procedure within a set timeframe.

NOTE: MSN message 18.16 should only be used when a certain screening procedure is performed as an alternative to another screening procedure.

E. If the claim is being denied for a non-covered screening procedure code such as HCPCS

G0122, use:

16.10 - Medicare does not pay for this item or service.

If an invalid procedure code is reported, the contractor will return the claim as unprocessable to the provider under current procedures.

***NOTE**: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 is discontinued and replaced with CPT 82270.

F. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) when furnished more than once in a 3-year period [at least 2 years and 11 full months (35 months total) must elapse from the date of the last screening], use:

15.19: "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.

15.20 - The following policies NCD 210.3 were used when we made this decision

Spanish Version – "Las siguientes políticas NCD210.3 fueron utilizadas cuando se tomó esta decisión"

NOTE: Due to system requirement, the Fiscal Intermediary Standard System (FISS) has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

G. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) *or Cologuard Plus (HCPCS 0464U – Effective October 3, 2024)* because the beneficiary is not between the ages of 45 and 85, use:

15.19 - "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.

15.20 - The following policies NCD 210.3 were used when we made this decision.

Spanish Version – "Las siguientes políticas NCD 210.3 fueron utilizadas cuando se tomó esta

decision."

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

H. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) *or Cologuard Plus (HCPCS 0464U – Effective October 3, 2024)* because the claim does not contain all of the ICD-10 diagnosis codes required, use:

15.19 - "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.

15.20 - The following policies 210.3 were used when we made this decision

Spanish Version – "Las siguientes políticas NCD210.3 fueron utilizadas cuando se tomó esta decisión"

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

I. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) *or Cologuard Plus (HCPCS G0464U – Effective October 3, 2024)* on institutional claims when submitted on a TOB other than 13X, 14X, and 85X, use:

21.25 - This service was denied because Medicare only covers this service in certain settings.

Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

If denying claims for CT Colonography code 74263 because the claim did not contain the required ICD-10 diagnosis claims, use:

MSN 15.4 – The information provided does not support the need for this service or item.

Spanish Version – La informacion proporcionada no confirma la necesidad para este servicio o articulo

60.8 - Remittance Advice Codes

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

All messages refer to ANSI X12N 835 coding.

A. If the claim for a screening FOBT, a screening flexible sigmoidoscopy is being denied because the patient is less than 45 years of age, use:

Claim Adjustment Reason Code (CARC) 6 "The procedure/revenue code is inconsistent with the patient's age," at the line level; and, Remittance Advice Remark Code (RARC) N129 "Not eligible due to patient's age"

B. If the claim for a screening FOBT, a screening colonoscopy, a screening flexible sigmoidoscopy is being denied because the time period between the test/procedure has not passed, use:

- CARC 119 "Benefit maximum for this time period or occurrence has been reached" at the line level.

C. If the claim is being denied for a screening colonoscopy (HCPCS G0105) because the patient is not at a high risk, use:

- CARC 46 "This (these) service(s) is (are) not covered" at the line level; and,
- RARC M83 "Service is not covered unless the patient is classified as a high risk." at the line level.

D. If the service is being denied because payment has already been made for a similar procedure within the set time frame, use:

- CARC 18, "Duplicate claim/service" at the line level; and,
- RARC M86 "Service is denied because payment already made for similar procedure within a set timeframe." at the line level.

E. If the claim is being denied for a non-covered screening procedure such as HCPCS G0122, use:

CARC 49, "These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam."

F. If the claim is being denied because the code is invalid, use the following at the line level:

- CARC B18 "Payment denied because this procedure code/modifier was invalid on the date of service or claim submission."

G. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) *or Cologuard Plus (HCPCS 0464U – Effective October 3, 2024)* when furnished more than once in a 3-year period [at least 2 years and 11 full months (35 months total) must elapse from the date of the last screening], use:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."

- RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

H. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) *or Cologuard Plus (HCPCS 0464U – Effective October 3, 2024)* when beneficiary is not between the ages 45-85, use:

- CARC 6: "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

- RARC N129: "Not eligible due to the patient's age."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

I. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) *or Cologuard Plus (HCPCS 0464U – Effective October 3, 2024)* when the claim does not contain ICD-10 diagnosis codes Z12.12 OR Z12.11), use:

- CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

J. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) *or Cologuard Plus (HCPCS 0464U – Effective October 3, 2024)* when claims are submitted on a TOB other than 13X, 14X, or 85X, use:

- CARC 170: "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if

present."

- RARC N95 – "This provider type/provider specialty may not bill this service."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

K. If denying a CT Colonography claim line-item for frequency requirement reasons, contractors shall use the following messages:

- *CARC 119: "Benefit maximum for this time period or occurrence has been reached."*
- *RARC N640 – Exceeds number/frequency approved/allowed within time period.*
- *Group Code: CO (Contractual Obligation)*
- *MSN 15.6 – The information provided does not support the need for this many services or items within this period of time.*
- *Spanish Version – La informacion proporcionada no confirma la necesidad de estos servicios o articulos en este period de tiempo.*

L. If denying a CT Colonography claim line-item when the beneficiary's age is not 45 or older, contractors shall use the following messages:

- *CARC 6 – The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF), if present.*
- *RARC N129 – Not eligible due to patient's age.*
- *Group Code – CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the item).*
- *(Part A only)*
- *MSN 15.4 – The information provided does not support the need for this service or item.*
- *Spanish Version – La informacion proporcionada no confirma la necesidad para este servicio o articulo.*

M. If denying a CT Colonography claim line-item when the claim submitted with the incorrect diagnosis(ses) codes(s), contractors shall use the following messages:

Claim Adjustment Reason Code (CARC) RARC - MA63 – Missing/incomplete/invalid principal diagnosis.

Remittance Advice Remark Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at: www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

(Part A only) MSN 15.19 - "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage- database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version -Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su medico

MSN 15.20 - "The following polices were used when we made this decision: NCD 270.3."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

NOTE: Due to a system requirement, the Fiscal Intermediary Shared System (FISS) has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

10.1.3 - Hepatitis B Vaccine

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

Effective for services furnished on or after September 1, 1984, the hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B, e.g., exposed to hepatitis B.

Effective for services furnished on or after January 1, 2025, the hepatitis B vaccine and its administration does not require an order by a doctor of medicine or osteopathy for Medicare claims.

See the Medicare Benefit Policy Manual, Chapter 15, for additional coverage requirements for hepatitis B vaccines to high risk and intermediate risk groups.

10.2.5 - Claims Submitted to MACs (Part B)

(Rev 13248; Issued:05-29-25; Effective:01-01-25 ; Implementation: 10-06-25)

Medicare does not require that the influenza virus, pneumococcal or COVID-19 vaccine be administered under a physician's order or supervision. Medicare still requires that the hepatitis B vaccine be administered under a physician's order with supervision. As a physician order is still required for claims for hepatitis B vaccinations, information on the ordering and/or referring physician must be entered on the claim.

Effective for services furnished on or after January 1, 2025, the hepatitis B vaccine and its administration does not require an order by a doctor of medicine or osteopathy for Medicare claims.

A. Reporting Specialty Code/Place of Service (POS) to CWF
Specialty

MACs (Part B) use specialty code 60 (Public Health or Welfare Agencies (Federal, State, and Local)) for Public Health Service Clinics (PHCs).

MACs (Part B) use specialty code 73 (Mass Immunization Roster Billers) for specialty code C1 centralized billers and specialty code A5 for pharmacies (all other suppliers (drug stores, department stores)).

Entities and individuals other than PHCs and pharmacies use the CMS specialty code that best defines their provider type. A list of specialty codes can be found in Pub. 100-04, Chapter 26. The CMS specialty code 99 (Unknown Physician Specialty) is acceptable where no other code fits.

Place of Service (POS)

State or local PHCs use POS code 71 (State or Local Public Health Clinic). POS 71 is not used for individual offices/entities other than PHCs (e.g., a mobile unit that is non-PHC affiliated should use POS 99). Preprinted Form CMS-1500s (08-05) used for simplified roster billing should show POS 60 (Mass Immunization Center) regardless of the site where vaccines are given (e.g., a PHC or physician's office that

roster claims should use POS 60). Individuals/entities administering influenza virus, pneumococcal, and COVID-19 vaccinations in a mass immunization setting (including centralized billers), regardless of the site where vaccines are given, should use POS 60 for roster claims, paper claims, and electronically filed claims.

Normal POS codes should be used in other situations.

Providers use POS 99 (Other Unlisted Facility) if no other POS code applies.

1.2 – Table of Preventive and Screening Services

(Rev 13248; Issued:05-29-25; Effective:01-01-25; Implementation: 10-06-25)

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	***Not Rated**	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished prior to January 1, 2017	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	**B**	WAIVED
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished on or after January 1, 2017	76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	**B**	WAIVED
Cardiovascular Disease Screening	80061	Lipid panel	**A**	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes	82947	Glucose; quantitative, blood (except reagent strip)	**B**	WAIVED

Screening Tests	82950	Glucose; post glucose dose (includes glucose)		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	**B**	WAIVED
	83036	Hemoglobin A1C Level	**B**	WAIVED
Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	***Not Rated**	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	**B**	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible

	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	**B**	WAIVED

	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	**A**	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	**A**	WAIVED

	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	**A**	WAIVED
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	**A**	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	**A**	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	**A**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	**A**	WAIVED

	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED

	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	**A**	WAIVED
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	**B**	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	**B**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	77063	Screening digital breast tomosynthesis, bilateral		WAIVED

	77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed		WAIVED

Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	**B**	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**

	77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites, axial skeleton, (e.g., hips, pelvis, spine), including vertebral fracture assessment.		WAIVED

	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED

NOTE:

Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the PT modifier; only the deductible is waived.

Coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier 33. When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (G0500 or 99153) are reported with only the PT modifier; only the deductible is waived.

For dates of service in calendar year (CY) 2023 through CY 2026, when the PT modifier is appended to at least one code on the claim to indicate that a screening colorectal cancer procedure, HCPCS G0104, G0105, or G0121, has become a diagnostic or therapeutic service, contractors shall continue to waive deductible, and shall apply a reduced coinsurance of 15% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service in CY 2027 through CY 2029, contractors shall continue to waive deductible and shall apply a reduced coinsurance of 10% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service on or after January 1, 2030, contractors shall continue to waive deductible and shall waive coinsurance for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim.

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
Colorectal Cancer Screening	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	**A**	WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
	81528	Oncology (colorectal) screening, quantitative real -time target and signal amplification of 10 DNA markers		WAIVED
	G0327	Colorectal cancer screening; blood-based biomarker Colon ca scrn;bld-bsd biomrk		WAIVED

	74263	*Computed tomography colonography*		*WAIVED*
	0464U	*Cologuard Plus*		*WAIVED*
	G0102	Prostate cancer screening; digital rectal examination	**D**	Not Waived

Prostate Cancer Screening	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	**I**	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived

Influenza Virus Vaccine	For the Medicare-covered codes for the influenza vaccines approved by FDA for current influenza vaccine season, please go to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html

	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	**B**	WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use		WAIVED
	90654	Influenza virus vaccine, split virus, preservative free, for intradermal use, for adults ages 18-64		WAIVED
	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6- 35 months of age, for intramuscular use		WAIVED

	90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED
	90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED
	90672	Influenza virus vaccine, live, quadrivalent, for intranasal use		WAIVED
	90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use		WAIVED

	90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use		WAIVED

	90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED

Pneumococcal Vaccine	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	**B**	WAIVED
	90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use		WAIVED
	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
Hepatitis B Vaccine	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	**A**	WAIVED
	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use		WAIVED

	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use		WAIVED
	G0010	Administration of Hepatitis B vaccine	**A**	WAIVED
Hepatitis C Virus Screening	G0472	Screening for Hepatitis C antibody	**B**	WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple- step method, HIV-1 or HIV-2, screening	**A**	WAIVED
	G0433	Infectious agent antigen detection by enzyme- linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED

	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2 , screening		WAIVED
Smoking Cessation for services furnished prior to October 1, 2016	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Smoking Cessation for services furnished on or after October 1, 2016	99406	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	99407	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Annual	G0438	Annual wellness visit, including PPPS, first visit	***Not**	WAIVED

Wellness Visit	G0439	Annual wellness visit, including PPPS, subsequent visit	**Rated**	WAIVED

Intensive Behavioral	G0447	Face-to-Face Behavioral Counseling for Obesity, 15 minutes	**B**	WAIVED
Therapy for Obesity	G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)		
Lung Cancer Screening	G0296	Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)	**B**	WAIVED
	G0297	Low dose CT scan (LDCT) for lung cancer screening		
COVID-19 Vaccine	See link	https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies		WAIVED