ATTACHMENT 6

COST DATA FORMS

a. Allowable Procedures and Relevant CPT, HCPCS, and APC Codes
b. Reimbursement Data File Form

6a.

Colorectal Cancer Screening Demonstration Program (CRCSDP)
Allowable Procedures and Relevant 2007 CPT, HCPCS and APC Codes
January 8, 2007

FOBT	
G0328*	Screening Fecal Occult Blood Test, immunoassay
G0394	Blood occult test (e.g., guaiac), feces, for single determination for colorectal neoplasm (i.e., patient was provided three cards or single triple card for consecutive collection).
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple cared for consecutive collection)
82274*	Blood, occult, fecal hemoglobin immunoassay
	Note: (codes 82271 (other sources) and 82272 (single specimen) are not included as they do not adhere to guideline-recommended screening)
Colonoscopy	
G0121	Screening colonoscopy on average risk individual
G0105	Screening colonoscopy on high risk individual
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45381	Colonoscopy, flexible, proximal to the splenic flexure; with directed submucosal injection(s), any substance.
45382	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45383	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
	Note: 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. SOME providers will use -modifier 52. This is an often confusing issue and depends upon why the procedure was interrupted.
Sigmoidoscopy	
G0104	Screening sigmoidoscopy
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple

45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45334	Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45335	Sigmoidoscopy, flexible; diagnostic, with directed submucosal injection(s), any substance
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45339	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
Barium Enema	
G0106	Colorectal screening; barium enema; as an alternative to G0104; screening sigmoidoscopy
G0120	Colorectal cancer screening; barium enema; as an alternative to G0105; screening colonoscopy.
G0122	Colorectal cancer screening; barium enema
74270	Radiologic examination, colon; barium enema, with or without KUB
74280	Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon
	Colorectal Cancer Screening
3017F	Colorectal cancer screening results documented and reviewed (PV)1 (Includes: fecal occult blood testing annually, flexible sigmoidoscopy every 5 years, annual fecal occult blood testing plus flexible sigmoidoscopy every 5 years, double-contrast barium enema every 5 years, or colonoscopy every 10 years)
Pathology	
88300	Surgical Pathology, gross examination only (surgical specimen)
88302	Surgical pathology, gross and microscopic examination (review level II)
88304	Surgical pathology, gross and microscopic examination (review level III)
88305	Surgical pathology, gross and microscopic examination, colon, colorectal polyp biopsy (review level IV)
88307	Surgical pathology, gross and microscopic examination, colon, segmental resection other than for tumor (review level V)
88309	Surgical pathology, gross and microscopic examination, colon, segmental resection for tumor or total resection (review level VI)
88312	Pathology: special stains
88342	Pathology: Immunocytochemistry, each antibody
Office Visits	
Initial, New Patients	
99201	Problem focused history & examination with straightforward medical decision
Established Patients	
99211	Problem focused history & examination with straightforward medical decision
Office Consultation for New and Established Patients	
99241	Problem focused history & examination with straightforward medical decision

APC (HOPPS codes for hospital based out-patient facilities)	
0143	Lower GI Endoscopy
0146	Level I Sigmoidoscopy
0147	Level II Sigmoidoscopy
0157	Colorectal Cancer Screening: Barium Enema
0158	Colorectal Cancer Screening: Colonoscopy
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy
Ambulatory Surgery Center (ACS) codes	
45378-SG through 45385-SG	The ASC bills for the facility fee using the same procedure code as the professional service and attaching a modifier -SG. The modifier indicates that the claim is for the facility fee ONLY.
Anesthesiology	
00810	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum
00100-01999	Anesthesia codes - CDC will only reimburse for standard anesthesia related to the endoscopic procedure
Modifiers (to be reported with appropriate CPT codes)	
-52	A discontinued procedure due to extenuating circumstances or those that threaten the well being of the patient. Not to be used to report elective cancellation.
-73	Discontinued procedure prior to anesthesia
-74	Discontinued procedure after to anesthesia
-26	Professional Component
-TC	Technical Component
-QW	Waived test under CLIA*
	Note: A procedure can be split into its "professional" and "technical" components and each can be billed separately as noted; however, a provider cannot bill using both codes. The sum of the two components equals the rate if billed with one code.

* The Current Procedural Terminology (CPT) codes for this test must have the modifier QW to be recognized as a waived test. These are tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Form Approved
OMB No. 0920-xxxx
Exp.
Date_____

6b.
Colorectal Cancer Screening Demonstration Program (CRCSDP)
Reimbursement Data Reporting Form

Reimbursement information will be collected for office visits, screening tests, diagnostic procedures and other services provided through CRCSDP to estimate the cost of providing these clinical services. Please submit the program reimbursement data (PRD) annually using an ASCII flat file. The following data elements are requested: client ID, billing codes (current procedural terminology [CPT], healthcare common procedural coding system [HCPCS] and ambulatory payment classification [APC], if applicable), an indicator if the payment was for bowel preparation, procedure date, charge amount and payment/reimbursement amount. Please use the file layout in Exhibit 1 to submit these data elements for each payment made (use one line for each payment).

File Format and Coding Specifications

Data Elements	Position	Length	Code Structure	Coding Instructions
Program	1-3	3	Numeric	• Same as CCDE • This field should always be completed.
Client ID	4-18	15	Numeric or alphanumeric	• Same as CCDE • This field should always be completed.
Procedure Date	19-26	8	Numeric	• MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of procedure. • The months of January-September and the days 1-9 must have leading zeros • If the date is unknown or not provided, leave

				the field blank.
Current Procedural Terminology [CPT] or Healthcare Common Procedural Coding System [HCPCS]	27-31	5	Numeric, Alphanumeric or blank	• A CPT code is a five digit numeric code. • There are approximately 7,800 CPT codes ranging from 00100 through 99499. • HCPC Codes are 5 character codes with a leading alphabet and rest numerals. • If the code is unknown or not provided, leave the field blank.
CPT Modifiers	32-33	2	Numeric or blank	• Two digit modifiers may be appended when appropriate to clarify or modify the description of the procedure. • If the modifier is unknown or not provided, leave the field blank.
Bowel Prep Payment	34	1	Numeric or blank	Enter the numeral 1 if the line item is for bowel prep payment, otherwise leave this field blank.
Ambulatory Payment Classification [APC]	35-38	4	Numeric or blank	• An APC code is a four digit numeric code. • If the number is unknown or not provided, leave the field blank.
Amount Charged	44-48	5	Numeric or blank	• Do not enter any leading zeroes • Do not add comma separators • If the number is unknown or not provided, leave the field

				blank. • Please right justify. That means if you are entering 1000, please enter in position number 2, 3, 4, and 5 and leave the first place blank.
Amount Paid/Reimbursed	39-43	5	Numeric or blank	• Do not enter any leading zeroes • Do not add comma separators • If the number is unknown or not provided, leave the field blank. • Please right justify. That means if you are entering 1000, please enter in position number 2, 3, 4, and 5 and leave the first place blank.