



### **Suggestions for billing with CPT codes G0328QW and 82274QW**

(\*Facilities performing those test categorized as waived must have a CLIA Certificate Of Waiver prior to billing Medicare. To get an application to apply for CLIA Waived status, Google: CMS 116. Click "Layout" and print the application form)

When iFOB testing was FDA approved and CLIA-waived in 2004 there were two new CPT codes assigned to differentiate this methodology from guaiac testing currently being used. Since the reimbursement for Hemosure iFOBT is significantly higher than that of guaiac testing, it is important that accounts bill insurers correctly to receive the full benefit of this increase. The following information should be useful to billing personnel who are unfamiliar with Hemosure.

Medicare is paying a national average reimbursement of \$21.82; however, there are a few states that pay less than this amount. Also, not all third party insurance companies pay \$21.82. Some will pay less, some pay significantly more, most determine how much they will pay based on a percentage of Medicare. Most HMO's and PPO's will pay for the test due to its approval status. Taking a typical mix of payers into account, most areas of the US maintain a reimbursement that closely holds to the \$21.82 average.

The proper approach to billing iFOBT's is to use the same rules that are used in billing guaiac-based FOB's. Simply substitute the new iFOB CPT codes for the old ones. It is very important to always use the "QW" modifier when billing iFOB test to designate it as CLIA-waived.

The **G0328QW** (screening) code is primarily used for Medicare. Please note: Some commercial insurers (and Railroad Insurance) also use the G0328QW code. They do so in order to simplify the processing of Medicare and Non-Medicare billing. It may also be used if Medicare is secondary to the primary insurer. G0328QW is an annual screen for fecal occult blood in patients over 50 years of age. It can only be used one time each twelve-month period and must always be supported by an appropriate screening diagnosis code, such as Z12.12 (Screening for malignant neoplasm of rectum). The code, Z00.00 (General adult medical examination without abnormal findings), should not be used since Medicare does not pay for routine annual exams. As a rule, screening CPT codes require a screening diagnosis code.

Non-Medicare patient screening uses the code **82274QW** with a screening diagnosis code. This would apply to annual physical exams billed to third-party payers. (\*\*Screening procedures require a screening code)

When using CPT 82274QW for diagnostic purposes, the same ICD-10 codes should be used as it is indicated when billing with the guaiac-based diagnostic CPT code 82270.

CPT 82274QW (diagnostic) can be used multiple times annually, has few limitations, and is dictated by the patient's medical symptoms. The 82274QW CPT does not use a screening diagnosis code when used for diagnostic testing; instead it would require a diagnostic ICD-10, such as D50.0 (iron deficiency anemia), etc.