



# Lung Cancer Screening Billing Guide

## Introduction

Lung cancer is the second most common cancer and the leading cause of cancer death in the US. The most common risk factor for lung cancer is smoking. Increasing age is also a risk factor for lung cancer. While lung cancer has an overall 5-year survival rate of just 20.5%, early-stage lung cancer has a better prognosis and is more amenable to treatment.<sup>1</sup>

Understanding coverage and reimbursement for lung cancer screening is important to expand implementation of this preventive service and increase screening rates among those at high risk. The information in this billing guide is intended for use by stakeholders including:

- State and local public health professionals working to increase rates of lung cancer screening by health care providers,
- Health systems and providers who are currently offering lung cancer screening including lung cancer program navigators<sup>2</sup> and program coordinators<sup>3</sup> who are facing challenges with coverage and reimbursement, and
- Health systems and providers who have chosen not to offer lung cancer screening in the past due to coverage and reimbursement issues.

This billing guide includes current coverage requirements for lung cancer screening, coding and documentation requirements, implementation challenges, and recommended resources for additional information.

## Coverage Requirements

On March 9, 2021, the United State Preventive Services Task Force (USPSTF) expanded its 'B' recommendation for annual screening for lung cancer with low-dose computed tomography (LDCT) to include adults who meet the following criteria:

- Age 50-80 years,
- No current signs or symptoms of lung cancer (asymptomatic),
- Tobacco smoking history of at least 20 pack-years (pack-years are calculated by multiplying the number of packs smoked per day by number of years smoked), and
- Currently smoke or have quit smoking within the last 15 years.

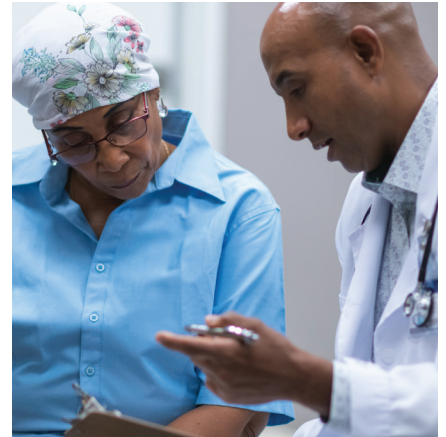
Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

## Medicare

In February 2022, Medicare announced expanded coverage for lung cancer screening with LDCT using criteria that largely mirrors the USPSTF but with a slightly different age range (50-77 years).

Before a Medicare beneficiary's first lung cancer screening, the beneficiary **must receive** a counseling and shared decision-making visit that meets all of the following criteria, and is appropriately documented in the beneficiary's medical records:

- Determination of beneficiary eligibility,
- Shared decision-making, including the use of one or more decision aids,
- Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment, and
- Counseling on the importance of maintaining cigarette smoking abstinence if formerly smoked, or the importance of smoking cessation if currently smoke and, if appropriate, furnishing of information about tobacco cessation interventions.



Medicare coinsurance and Part B deductible are waived for this preventive service.

## Medicare Advantage (MA)

The Medicare program covers a wide range of health care services when they are medically necessary for beneficiaries. Medicare Advantage is designed to cover the same services as Medicare (also known as fee-for-service Medicare), but MA organizations may impose additional requirements, such as requiring that beneficiaries use only in-network providers for certain health care services, requiring prior authorization before certain services can be provided or requiring referrals for specialty care services.<sup>4</sup>

## Medicaid

Medicaid provides health coverage to millions of individuals, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Section 4106 of the Affordable Care Act (ACA) provides that states who elect to cover all of the USPSTF grade A and B recommended preventive services and all of the Advisory Committee on Immunization Practices recommended vaccines and their administration with no cost-sharing shall receive an increased federal match for such services.<sup>5</sup> However standard Medicaid programs are not required to cover these screenings. Thus, coverage of lung cancer screening in Medicaid varies by state.

As of October 2023, 49 Medicaid fee-for-service programs cover lung cancer screening. Coverage may also vary between fee-for-service and managed care plans within a state's Medicaid program. The American Lung Association's online [State Lung Cancer Screening Coverage Toolkit](#) provides updated coverage information about each state's fee-for-service Medicaid program.<sup>6</sup>

### Medicaid Expansion

Under the Affordable Care Act, states can choose to expand Medicaid coverage to all adults up to 138% of the federal poverty level. As of September 2024, 41 states and the District of Columbia have adopted Medicaid expansion.<sup>7</sup> While standard Medicaid plans are not required to cover lung cancer screening, state Medicaid programs are required to provide Medicaid Expansion enrollees this and other USPSTF graded “A” or “B” preventive services at no cost.

### Private Insurance

As detailed below, specific private insurance plans are required to cover lung cancer screening and others are not. However, private insurance plans that cover screening may require prior authorization and use of in-network providers, similar to Medicare Advantage.

### Employer-Sponsored

As a result of the ACA, most private insurance plans are required to cover USPSTF A and B services at no cost to the member. For employer-sponsored plans that are “grandfathered”<sup>8</sup> under the ACA, LDCT screening may not be covered without cost sharing. Plan documents should clearly disclose if a plan is grandfathered. To be certain, contact the insurance company.

### Individual Plan

Many types of individual plans – including short-term limited-duration plans, association health plans and plans sold directly by farm bureaus or health ministries – do not have to follow ACA standards and thus may not cover lung cancer screening or may impose cost-sharing if it is covered.

### State Health Insurance Marketplace Plan

Individual insurance plans sold on the state health insurance marketplace must cover USPSTF A and B services, including the LDCT screening benefit described above, with no cost-sharing.

## Coding and Documentation Requirements

Standardized medical codes allow lung cancer screening centers to bill government and commercial payers for their services. Medical codes tell payers the patient’s diagnosis; medical necessity for treatments, services, or supplies the patient received; treatments, services, and supplies provided to the patient; and any unusual circumstances or medical conditions that affected those treatments and services.<sup>9</sup>

### Common Types of Medical Codes

- Current Procedure Terminology (**CPT®**) – This code set, owned and maintained by the American Medical Association, includes more than 8,000 five-character alphanumeric codes describing services provided to patients by physicians, paraprofessionals, therapists, and others. Most outpatient services are reported using the CPT® system. Physicians also use it to report services they perform in inpatient facilities.
- International Classification of Diseases, 10th Edition, Procedural Coding System (ICD-10-PCS) – ICD-10-PCS is a 130,000 alphanumeric code set used by hospitals to describe surgical procedures performed in operating, emergency department, and other settings.
- Health Care Procedural Coding System, Level II (**HCPCS Level II**) – HCPCS Level II’s 7,000-plus alphanumeric codes are used for many more purposes, such as quality measure tracking, outpatient surgery billing, and academic studies.

There are two current codes associated with lung cancer screening:

- CPT **G0296**: counseling visit to discuss the need for lung cancer screening using LDCT scan (service is for eligibility determination and shared decision making). This is listed as a permanent telehealth code. The code is payable in the facility and the non-facility setting.
- CPT **71271**: CT, thorax, low dose for cancer screening without contrast material. This code became effective January 1, 2021.

CPT codes 71250-71270 **are no longer relevant** to report lung cancer screening. Additionally, HCPCS code G0297 was deleted at the end of 2021. **It is no longer valid.**

Medicare will deny lung cancer screening claims that do not include these ICD-10 diagnosis codes:

- Z87.891 those who have formerly smoked (personal history of nicotine dependence)
- F17.21 those who currently smoke (nicotine dependence)
  - F17.210 Nicotine dependence, cigarettes, uncomplicated (most commonly used and accepted)
  - F17.211 Nicotine dependence, cigarettes, in remission
  - F17.213 Nicotine dependence, cigarettes, with withdrawal
  - F17.218 Nicotine dependence, cigarettes, with other nicotine-induced disorders
  - F17.219 Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders

For scans needed more frequently than once per year (diagnostic CT), the CPT code is 71250, although some lung cancer screening programs have had challenges with Medicare denying these claims.

## Smoking Cessation Interventions

Many individuals who will undergo lung cancer screening are currently smoking. These patients are not only at risk for developing lung cancer, but also carry the risk of developing a host of other smoking related diseases, and cessation at any age is beneficial. Counseling and pharmacotherapy are evidence-based strategies which are proven effective to help people quit smoking. Smoking cessation broadens the impact of any lung cancer screening program well beyond the endpoints of cancer diagnosis and cancer mortality to reduce risk from many other diseases and can positively impact many more patients than the small percentage that have cancer.<sup>10</sup>

Smoking cessation interventions and services must be offered to those who currently smoke. Cessation counseling in the G0296 code for the shared decision-making visit should include counseling on the importance of maintaining cigarette smoking abstinence if they formerly smoked, the importance of smoking cessation of those who currently smoke, and furnishing of information about tobacco cessation interventions.<sup>11</sup>

If smoking cessation counseling is provided separately from the shared decision-making visit, it may be documented using the following CPT codes:

- 99406: Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- 99407: Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Smoking cessation counseling can also be reported in addition to an evaluation and management (E&M) visit, performed on the same day by the same licensed independent providers, by appending 25 modifier to the appropriate level of E&M service.<sup>12</sup> Additionally, smoking cessation counseling can be performed via telehealth.<sup>13</sup> For additional information on billing for tobacco cessation counseling, see the American Lung Association's [Billing Guide for Tobacco Screening and Cessation](#).<sup>14</sup>

## Adding Smoking Cessation Services to Lung Cancer Screening Programs

Patients who quit smoking at or around the time of a lung cancer diagnosis have a 29% improvement in their overall survival compared with those who continue smoking.<sup>15</sup> Treating providers should educate lung cancer patients about the benefits of quitting smoking even after diagnosis and provide them with the necessary smoking cessation support using the health systems change model. According to the Centers for Disease Control and Prevention, health systems change involves institutionalizing tobacco cessation interventions into routine clinical care in health care systems to ensure that (1) every patient is screened for tobacco use and tobacco use status is documented, and (2) patients who use tobacco are advised to quit and provided with options for evidence-based treatments.<sup>16</sup> When a health system seeks to intervene with tobacco users at every visit, it can significantly increase patients' tobacco cessation.

Broadly speaking, health systems change resources address general issues of interest to lung cancer screening programs. Additional focused programs have specific strategies for cancer centers interested in integrating smoking cessation into their workflows to increase the focus on cessation within the organization. Please refer to the Additional Resources section for more information. Additionally, the American Lung Association has technical assistance opportunities including webcasts, toolkits, a podcast and a resource library, all of which can be found at [Lung.org/cessationta](https://Lung.org/cessationta).

## Implementation Challenges

While the updated USPSTF and Medicare guidelines offer some additional clarity to lung cancer programs, challenges remain implementing screening programs. Building relationships with various payers' provider relations staff may be required for lung cancer programs to develop workflows that will circumvent these common barriers.

State health department lung cancer programs can engage with local payers to clarify billing and reimbursement issues, creating and sharing tools with lung cancer programs in the state. This is similar to work that many state health tobacco programs have done related to cessation coverage and billing.

Several common challenges are described below.

### Timing of Health Plan Compliance

Most private health plans (including individual, small group, large group, and self-insured plans) and Medicaid expansion programs endeavoring to comply with the USPSTF criteria dated March 09, 2021 need to update their coverage for plan years beginning on or after March 31, 2022.<sup>17</sup> Plan years beginning between April 1 and December 31, 2022 or between January 1 and February 28, 2023 should come into compliance over the next several months. This lag may cause claims denials in the meantime, if older plans do not cover lung cancer screening for the expanded high-risk population ahead of the required timeline.

### Ordering Provider

Before the first lung cancer screening occurs, Medicare requires that the beneficiary receive an order for a LDCT scan during a lung cancer screening counseling and shared decision-making visit. Orders for subsequent annual LDCT screenings may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (physician assistant, nurse practitioner or clinical nurse specialist). Many private insurers follow Medicare's lead on similar requirements, so incorporating these requirements into the workflow at the screening program may be beneficial.

A written order is considered a best practice, though it is no longer specifically required by Medicare. For patients that self-refer or are at the hospital or health system for other reasons and want lung cancer screening, some centers will enter the order from one of their own providers, and then assign someone to review all of the findings with the patient if they do not have a primary care physician.

### Prior Authorization Mechanics

While the Medicare guidance allows the shared decision-making visit to be on the same day as the LDCT scan, if a health plan requires prior authorization, it may need to be completed before that date. This has been particularly challenging for facilities that have established a workflow to have the shared decision-making the same day as the LDCT scan, because the shared decision-making visit includes eligibility determination, which may be the first time the lung cancer screening program is alerted to the need for the prior authorization. Some prior authorization decisions are received the same day, but they may take longer for approval. Understanding which payers will require the prior authorization and if it is completed as an automated authorization if the patient meets standard criteria (vs. clinical reviewer) may assist the screening program in developing a workflow to include one or two visits per patient, depending on the payer. The need for two visits creates additional patient barriers (time off work, transportation, childcare, etc.) so communication with payers may be important.

Additionally, health plans may have policies about the facility location, which could interrupt the process of having the entire episode of care through a single lung cancer program. Some navigators have been able to request reconsideration based on continuity of care, availability of a previous scan or other pre-procedure care, but these are individual medical necessity decisions, which also will impact the lung cancer program's workflows.

### Tobacco Cessation Claims Denials

Tobacco cessation treatment is another USPSTF A rated preventive service that most private health plans and Medicaid expansion programs should cover with no cost-sharing. This includes individual counseling, group counseling and seven FDA-approved pharmacotherapies.

It is important for the lung cancer screening program to recognize that the shared decision-making visit code (G0296) includes tobacco cessation counseling as part of the visit. Thus, the lung cancer program cannot charge for counseling the same day as the shared decision-making visit. On subsequent days, cessation counseling can be billed with an E&M code (see above).

Individual health plans may limit the number of counseling visits covered (depending on plan payment parameters) and it may be challenging to determine if another provider has billed against that limit. This is another area that may impact the lung cancer program's workflows.

Lung cancer programs have reported challenges with coverage of cessation medications from payers that should be providing them at no cost. This may be an area where lung cancer programs or public health agencies can work with payers to ensure appropriate coverage.



## Conclusion

Expanding lung cancer screening is critical to defeating lung cancer. Public health and lung health organizations, state and location coalitions, and healthcare professionals can partner to overcome challenges and work with payers to smooth implementation barriers, improve billing and reimbursement success and optimize care for eligible patients.



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## Lung Cancer Screening Coverage and Reimbursement – Key Points

### Codes to Know:

|                                                    |                                                                                      |
|----------------------------------------------------|--------------------------------------------------------------------------------------|
| Shared decision-making (SDM)                       | G0296 with Z87.891 or F17.210                                                        |
| Lung cancer screening (LDCT)                       | 71271 with Z87.891 or F17.210                                                        |
| Tobacco cessation counseling (outside of SDM)      | 99406 (greater than 3 minutes, up to 10 minutes)<br>999407 (greater than 10 minutes) |
| Diagnostic CT (more frequently than once per year) | 71250                                                                                |

### Implementation Challenges and Resources:

| Common Challenges                                    | Resources                                                                                                         |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| Coverage Issues and Timing of Health Plan Compliance | <a href="#">American Lung Association Lung Cancer Screening Coverage Chart</a>                                    |
| Ordering Provider                                    | <a href="#">Medicare's Updated Coverage Policy (Feb. 2022)</a>                                                    |
| Tobacco Cessation Claims                             | <a href="#">American Lung Association Billing Guide for Tobacco Screening and Cessation</a>                       |
| General Billing Issues                               | <a href="#">American College of Radiology Lung Cancer Screening Economics &amp; Billing Quick Reference Guide</a> |

### Additional Resources:

- [USPSTF's Lung Cancer Screening Recommendation \(March 2021\)](#)
- [American Lung Association FAQ on Recent Medicare Changes](#)
- [American Lung Association Resource Hub for Effective Tobacco Cessation Coverage and Health Systems Change](#)
- [Million Hearts Tobacco Cessation Change Package](#)
- [Agency for Healthcare Research and Quality Systems Change: Treating Tobacco Use and Dependence](#)
- [2022 Commission on Cancer \(CoC\) and NAPBC Assessment of Smoking in Newly Diagnosed Cancer Patients](#)
- [PDSA Quality Improvement Project and Clinical Study: Just Ask](#)
- [NCI Cancer Moonshot-Funded Cancer Center Cessation Initiative \(C3I\)](#)

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- <sup>1</sup> US Preventive Services Task Force, “Screening for Lung Cancer: US Preventive Services Task Force Recommendation Statement,” *JAMA* 325, no. 10 (March 9, 2021): 962, <https://doi.org/10.1001/jama.2021.1117>.
- <sup>2</sup> Christine S. Shusted et al., “The Case for Patient Navigation in Lung Cancer Screening in Vulnerable Populations: A Systematic Review,” *Population Health Management* 22, no. 4 (August 1, 2019): 347–61, <https://doi.org/10.1089/pop.2018.0128>.
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- <sup>4</sup> “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care,” *U.S. Department of Health and Human Services Office of Inspector General* (April, 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.
- <sup>5</sup> Cindy Mann, “State Medicaid Director Letter SMD#13-002,” *Center for Medicaid and CHIP Services*, (February 1, 2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-002.pdf>.
- <sup>6</sup> “State Lung Cancer Screening Coverage Toolkit,” *American Lung Association*, (September 2021), <https://www.lung.org/lung-health-diseases/lung-disease-lookup/lung-cancer/saved-by-the-scan/resources/state-lung-cancer-screening>.
- <sup>7</sup> “Medicaid Expansion and Lung Cancer,” *American Lung Association*, (2020), [https://www.lung.org/getmedia/13a5c27f-c3de-4b57-af22-bee6e578831c/medicaid-expansion-and-lcs-one-pager-2020-final\(1\).pdf](https://www.lung.org/getmedia/13a5c27f-c3de-4b57-af22-bee6e578831c/medicaid-expansion-and-lcs-one-pager-2020-final(1).pdf).
- <sup>8</sup> According to [HealthCare.gov](https://www.healthcare.gov), a Grandfathered Health Plan is an individual health insurance policy purchased on or before March 23, 2010. These plans weren’t sold through the Marketplace, but by insurance companies, agents, or brokers. They may not include some rights and protections provided under the Affordable Care Act.
- <sup>9</sup> The American Academy of Professional Coders. “What Is Medical Coding?,” AAPC, (2022), <https://www.aapc.com/medical-coding/medical-coding.aspx>.
- <sup>10</sup> Matthew A. Steliga and Ping Yang, “Integration of Smoking Cessation and Lung Cancer Screening,” *Translational Lung Cancer Research* 8, no. 1 (May 2019): S88–94, <https://doi.org/10.21037/tlcr.2019.04.02>.
- <sup>11</sup> “Low-Dose CT Lung Cancer Screening FAQ,” *American College of Radiology*, (2022), <https://www.acr.org/Clinical-Resources/Lung-Cancer-Screening-Resources/FAQ>.
- <sup>12</sup> “ACR Lung Cancer Screening Economics & Billing Quick Reference Guide,” *American College of Radiology* (April, 2022), [https://www.acr.org/-/media/ACR/Files/Lung-Cancer-Screening-Resources/April-2022-LCS-Billing-One-Pager-Updates\\_F.pdf](https://www.acr.org/-/media/ACR/Files/Lung-Cancer-Screening-Resources/April-2022-LCS-Billing-One-Pager-Updates_F.pdf).
- <sup>13</sup> ACR Lung Cancer Screening Economics & Billing Quick Reference Guide
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