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Incomplete Colonoscopies Billed with Modifier 53 for Critical Access Hospital (CAH) Method II Providers

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Related Change Request (CR) Number: 10937
Related CR Release Date: October 26, 2018
Effective Date: April 1, 2019
Related CR Transmittal Number: R4153CP
Implementation Date: April 1, 2019

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Critical Access Hospital (CAH) Method II providers submitting claims to Medicare Administrative Contractors (MACs) for colonoscopy services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10937 implements the payment methodology for incomplete colonoscopy procedures (Healthcare Common Procedure Coding System (HCPCS) codes 44388, 45378, G0105, and G0121 with a modifier 53) for CAH Method II providers. Please make sure your billing staffs are aware of these changes.

BACKGROUND

Physicians and non-physician practitioners billing on Type of Bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue code (REV) 96X, 97X, or 98X) based on the Medicare Physician Fee Schedule (MPFS) supplemental file.

According to Current Procedural Terminology (CPT) instruction, prior to Calendar Year (CY) 2015, an incomplete colonoscopy was defined as a colonoscopy that did not evaluate the colon past the splenic flexure (the distal third of the colon). Physicians were previously instructed to report an incomplete colonoscopy with 45378 and append modifier 53 (discontinued procedure), which is paid at the same rate as a sigmoidoscopy.

In CY 2015, the CPT instruction changed the definition of an incomplete colonoscopy to a colonoscopy that does not evaluate the entire colon. The 2015 CPT Manual states,

> "When performing a diagnostic or screening endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the

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colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report 45378 (colonoscopy) or 44388 (colonoscopy through stoma) with modifier 53 and provide appropriate documentation."

Therefore, in accordance with the change in CPT Manual language, the Centers for Medicare & Medicaid Services (CMS) has applied specific values in the Medicare physician fee schedule for the following codes:

- 44388-53, [44388 (colonoscopy through stoma) with modifier 53]
- 45378-53, [45378 (colonoscopy) with modifier 53]
- G0105-53, [G0105 (colorectal cancer screening, colonoscopy on individual at high risk) with modifier 53] and
- G0121-53 [G0121 (colorectal cancer screening, colonoscopy on individual not meeting criteria for high risk) with modifier 53]

Effective for services performed on or after April 1, 2019, the MPFS database will have specific values for the codes listed above. Given that the new CPT definition of an incomplete colonoscopy also includes colonoscopies where the colonoscope is advanced past the splenic flexure but not to the cecum, CMS has established new values for incomplete diagnostic and screening colonoscopies performed on or after January 1, 2016. Incomplete colonoscopies are reported with the 53 modifier. Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

In situations where a CAH has elected payment Method II for CAH patients, payment will be consistent with payment methodologies currently in place as outlined in the Medicare Claims Processing Manual (Publication 100-04, Chapter 12, Section 30.1 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf), and Chapter 18, Section 60.2 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf).

As such, CAHs that elect Method II payment must 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.

When MACs apply the adjusted payment for incomplete colonoscopies, they will return the following remittance codes:

- Claim Adjustment Reason Code 59 - Processed based on multiple or concurrent procedure rules. (For example, multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
- Group code "CO" - contractual obligation

ADDITIONAL INFORMATION

The official instruction, CR10937, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4153CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
October 26, 2018	Initial article released.