CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1160	**Date: JANUARY 19, 2007**
	Change Request 5387

SUBJECT: Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change

I. SUMMARY OF CHANGES: Effective for services on or after January 1, 2007, contractors shall apply a beneficiary 25 percent coinsurance for all colorectal cancer screening colonoscopies performed in ASCs and in hospital outpatient departments. The 25 percent coinsurance is currently being applied in the Outpatient Prospective Payment System (OPPS) PRICER for OPPS hospitals. However, it is not currently being applied to ASCs or non-OPPS hospitals.

Contractors shall also take action to ensure a 25 percent coinsurance payment is applied to non-OPPS hospitals for colorectal cancer screening flexible sigmoidoscopies. The 25 percent coinsurance is currently being applied in the Outpatient Prospective Payment System (OPPS) PRICER for OPPS hospitals. However, it is not being applied to non-OPPS hospitals.

The IOM, Publication 100-04, Chapter 1, Section 30; Chapter 14 Section 40; and Chapter 18, Section 60 have been updated to reflect this change.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

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	1/30/30.3.1/Mandatory Assignment on Carrier Claims
R	14/40/2/Carrier Adjustment of Base Payment Rates
R	18/TOC
R	18/60/60.1/Payment
N	18/60/60.1.1/Deductable and Coinsurance
R	18/60/60.2.2/Ambulatory Surgical Center (ASC) Facility Fee

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1160	Date: January 19, 2007	Change Request: 5387

SUBJECT: Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change

Effective Date: January 1, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: Section 1834(d)(3) of the Social Security Act, in part, imposes a beneficiary coinsurance of 25 percent, for colorectal cancer screening colonoscopies that are performed in Ambulatory Surgical Centers (ASCs) and in hospital outpatient departments. The 25 percent coinsurance is currently being applied in the Outpatient Prospective Payment System (OPPS) PRICER for OPPS hospitals. However, it is not being applied to ASCs or non-OPPS hospitals.

Section 1834(d)(2) of the Social Security Act, also imposes a beneficiary coinsurance of 25 percent for colorectal cancer screening flexible sigmoidoscopies that are performed in hospital outpatient departments. The 25 percent coinsurance is currently being applied in the Outpatient Prospective Payment System (OPPS) PRICER for OPPS hospitals. However, it is not being applied to non-OPPS hospitals.

In addition, as part of Section 5113 of the Deficit Reduction Act of the DRA, effective for services on or after January 1, 2007, there is no deductible for colorectal screening services performed in ASCs or hospital outpatient departments. This will be implemented under CR 5127, transmittal 1004, dated July 21, 2006.

B. Policy: Contractors compute the 25 percent coinsurance amount for colorectal cancer screening colonoscopies, performed in ASCs, based on the Medicare ASC facility payment payment rate for services performed beginning January 1, 2007. The 25 percent coinsurance amount for colorectal screening sigmoidoscopies and colonoscopies, performed in non-OPPS hospitals is based on the payment methodology currently in place for colorectal cancer screening services performed beginning January 1, 2007.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5387.1	Effective for services performed on or	X			X				X		X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	after January 1, 2007, contractors shall take action to ensure a 25 percent coinsurance payment is applied to the following services when performed in an ASC: G0105 - Colorectal cancer screening; colonoscopy on individual at high risk G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk. NOTE: This change applies for ASC bills and not physician bills.											
5387.1.1	CWF shall create a new value of 4 for the reimbursement indicator field. 4 will equal 75 percent reimbursement on HUBC.										X	
5387.2	Effective for claims with dates of service on or after January 1, 2007, Contractors shall take action to ensure a 25 percent coinsurance payment is applied to non-OPPS hospitals for the following colorectal services: • G0104-Colorectal cancer screening; flexible sigmoidoscopy, • G0105-Colorectal cancer screening; colonoscopy on individual at high risk, and • G0121- Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk. NOTE: The 25 percent coinsurance is currently being applied in the OPPS PRICER for OPPS hospitals.	X		X				X				
5387.3	Contractors subject to HIGLAS shall send the new rate to HIGLAS on the	X		X	X			X				*HIGLAS*

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	HIGLAS 837 in the 2400 loop in the detail reimbursement rate segment.											
5387.4	Contractors shall not search for or adjust claims for colorectal cancer screening colonoscopy or screening flexible sigmoidoscopy tests that have been paid prior to July 2, 2007. However, contractors shall adjust claims brought to their attention.	X		X	X							
5387.5	Contractors shall use the following two new Medicare Summary Notices (MSN) for services listed in 5387.2 • 61.41, "You pay 25% of the Medicare-approved amount for this service." • 61.41, "Usted paga el 25% de la cantidad aprobada por Medicare por este servicio."	X		X	X			X	X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5387.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ . You will also receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider	X		X	X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Payment Policy: contact Chuck Braver at chuck.braver@cms.hhs.gov or (410) 786-6719
Claims Processing: contact Yvette Cousar at yvette.cousar@cms.hhs.gov or (410) 786-2160 for Carriers; and Bill Ruiz at william.ruiz@cms.hhs.gov or (410) 786-9283, or Stuart Baranco at stuart.barranco@cms.hhs.gov or (410) 786-6521, for FIs.

Post-Implementation Contact(s):
Appropriate Regional Office

VI. FUNDING

A. No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

30.3.1 - Mandatory Assignment on Carrier Claims

(Rev.1160, Issued: 01-19-07, Effective: 01-01-07, Implementation: 07-02-07)

The following practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance.

Assignment is mandated for the following claims:

- Clinical diagnostic laboratory services and physician lab services;
- Physician services to individuals dually entitled to Medicare and Medicaid;

Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.

NOTE: The provider type Mass Immunization Roster Biller can only bill for influenza and pneumococcal vaccinations and administrations. These services are **not** subject to the deductible or the 20 percent coinsurance.

- Ambulatory surgical center services *(No deductible and 25 % coinsurance for colorectal cancer screening colonoscopies {G0105 and G0121})*;
- Home dialysis supplies and equipment paid under Method II;
- Drugs and biologicals; and,
- Ambulance services

When these claims are inadvertently submitted as unassigned, carriers process them as assigned.

Note that, unlike physicians, practitioners, or suppliers bound by a participation agreement, practitioners/entities providing the services/supplies identified above are required to accept assignment only with respect to these services/supplies (unless they have signed participation agreements which blanket the full range of their services).

The carrier system must be able to identify (and update) the codes for those services subject to the assignment mandate.

For the practitioner services of physicians and independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Nor is the acceptance of assignment mandatory for the suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may nevertheless voluntarily agree to participate to take advantage of the higher payment rate, in which case the participation status makes assignment mandatory for the term of the agreement. Such an agreement is known as the Medicare Participating Physician or Supplier Agreement. (See §30.3.12.2 Carrier Participation Agreement.) Physicians, practitioners, and suppliers who sign this agreement to participate are agreeing to accept assignment on all Medicare claims. The Medicare Participation Agreement and general instructions are on the CMS Web site.

40.2 - Carrier Adjustment of Base Payment Rates

(Rev.1160, Issued: 01-19-07, Effective: 01-01-07, Implementation: 07-02-07)

The payment rates established for the groups of ASC procedures (see §30) are standard base rates that have been adjusted to remove the effects of regional wage variations. When carriers process claims for ASC facility services, they adjust the base rates to reflect the wage index value applicable to the area in which the ASC is located. The Medicare payment for ASC facility services is equal to 80 percent of the wage-adjusted standard payment rate. Beneficiaries are responsible for a 20 percent *coinsurance* payment for ASC facility services once their deductible is satisfied. The exception is *for colorectal cancer screening colonoscopies (G0105 and G0121). Effective for these services performed on or after January 1, 2007, there is no deductible and a 25 percent coinsurance payment applies. Use Medicare Summary Notice (MSN) 61.41, "You pay 25% of the Medicare-approved amount for this service."*

The wage index includes the wage and salary levels of certain health care professionals in both urban and nonurban locations, compared to a national norm of 1.0. Areas with above average wage levels have index numbers greater than 1.0, while areas with below average wage levels have index numbers below l.0.

Each MSA within a State has a separate index, and there is one index for all rural areas within a State.

Also each group's payment rate has a labor and a nonlabor component, and only the labor component is adjusted for the wage index.

Carriers must adjust ASC payment rates by following these steps. Carriers round calculations to the fourth decimal place at each step.

1. Separate each group's payment rate into its labor (.3445) and nonlabor (.6555) components. To determine the payment rate that is subject to the labor adjustment for Group 6 and Group 8, first subtract the IOL allowance from each group's composite payment rate. (This is because IOLs are not subject to adjustment for labor costs, therefore the IOL allowance must be subtracted from the composite payment rate before applying the wage index adjustment, and then added back in the calculation as described in step 5).

2. Identify the appropriate wage index value for the ASC's location.

3. Multiply the labor component (payment rate multiplied by .3445 - Step 1) by the appropriate wage index value.

4. Add the adjusted labor component (Step 3) to the nonlabor component (payment rate multiplied by .6555 - Step 1) to determine the total adjusted payment rate.

5. For Groups 6 and 8, add the IOL allowance to the total adjusted payment rate (Step 4) to determine the total adjusted composite rate for the procedures in these groups.

This provides the ASC payment rate for the ASC. Round the final amount to the nearest dollar.

Note that coinsurance (and deductible if applicable) is deducted from the payment amount.

EXAMPLE 1:

This example shows how to determine payment for an ASC with a wage index value of 1.0985 for a procedure in payment group 4 ($612). The labor related portion is 34.45 percent and the nonlabor related portion is 65.55 percent.

Use the steps illustrated in Example 1 to adjust payment rates for groups whose payment rate does not include an allowance for an IOL.

Wage Adjusted Rate

= (($612 x .3445) x 1.0985) + ($612 x 0.6555)

= ($210.83 x 1.0985) + $401.17

= $231.60 + $401.17

= $632.77

Final Payment

= $632.77 x .80

= $506.21

EXAMPLE 2:

The following shows how to determine payment to an ASC for services furnished in January 2002 with a wage index value of 1.0714, for each of the two procedures in Group 8 ($949). Use the steps in this example to calculate payment amounts for each of the two procedures in Group 6 as well. Subtract $150 (the IOL allowance) from the composite payment rate ($949 for Group 8 and $806 for Group 6) before adjusting for wage variation.

Wage Adjusted Rate

= [(($949 - $150) x 0.3455) x 1.0714] + [($949 - $150) x 0.6555]

= [($799 x 0.3455) x 1.0714] + ($799 x 0.6555)

= ($276.05 x 1.0714) + $523.74

= $295.76 + $523.74

= $819.51

Composite Adjusted Rate

= $819.51 + $150

= $969.51

Final Payment

= $969.51 x .80

= $775.61

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

(Rev. 1160, 01-19-07)

60.1.1 – Deductible and Coinsurance

60.1 - Payment

(Rev.1160, Issued: 01-19-07, Effective: 01-01-07, Implementation: 07-02-07)

Payment (contractor) is under the MPFS except as follows:

- Fecal occult blood tests (82270* (G0107*) and G0328) are paid under the clinical diagnostic lab fee schedule except reasonable cost is paid to all non-OPPS hospitals, including CAHs, but not IHS hospitals billing on TOB 83x. IHS hospitals billing on TOB 83x are paid the ASC payment amount. Other IHS hospitals (billing on TOB 13x) are paid the OMB approved 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 on TOB 13X. Payment from all hospitals for non-patient laboratory specimens on TOB 14X will be based on the clinical diagnostic fee schedule, including CAHs and Maryland waiver hospitals.
- 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* (G0105 and G0121) and barium enemas (G0106 and G0120) are paid under OPPS for hospital outpatient departments and on a reasonable costs basis for CAHs or current payment methodologies for hospitals not subject to OPPS. Also colonoscopies may be done in an Ambulatory Surgical Center (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 HIS hospitals when the service is billed on TOB 83x.

The following screening codes must be paid at rates consistent with the diagnostic codes indicated.

Screening Code	**Diagnostic Code**
G0104	45330
G0105 and G0121	45378
G0106	74280
G0120	74280

Prior to January 1, 2007, deductible and coinsurance apply to the codes listed in chart above. Beginning with services provided on or after January 1, 2007, Section 5113 of the Deficit Reduction Act of 2005 waives the requirement of the annual Part B deductible for these services. Coinsurance still applies.

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 codes G0104, G0105, G0106, 82270* (G0107*), G0120, G0121 and G0328 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 <u>all</u> hospitals

Payment for colorectal cancer screenings (82270* (G0107*) and G0328) 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 January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with 82270.

60.1.1 – Deductible and Coinsurance

(Rev.1160, Issued: 01-19-07, Effective: 01-01-07, Implementation: 07-02-07)

There is no deductible and no coinsurance or copayment for the fecal occult blood tests (G0107 and G0328). Prior to January 1, 2007 deductible and coinsurance apply to other colorectal procedures (G0104, G0105, G0106, G0120, and G0121). After January 1, 2007, the deductible is waived for those tests.

NOTE: A 25 percent coinsurance applies for all colorectal cancer screening colonoscopies (G0105 and G0121) performed in a ASCs and non-OPPS hospitals effective for services performed on or after January 1, 2007. The

25 percent coinsurance was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

A 25 percent coinsurance also applies for colorectal cancer screening sigmoidoscopies (G0104) performed in non-OPPS hospitals effective for services performed on or after January 1, 2007. The 25 percent coinsurance was implemented in OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

60.2.2 - Ambulatory Surgical Center (ASC) Facility Fee

(Rev.1160, Issued: 01-19-07, Effective: 01-01-07, Implementation: 07-02-07)

CPT code 45378, which is used to code a diagnostic colonoscopy, is on the list of procedures approved by Medicare for payment of an ambulatory surgical center facility under §1833(I) of the Act. CPT code 45378 is currently assigned to ASC payment group 2. Code G0105, colorectal cancer screening; colonoscopy on individuals at high risk, was added to the ASC list effective for services furnished on or after January 1, 1998. Code G0121, colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk, was added to the ASC list effective for services furnished on or after July 1, 2001. Codes G0105 and G0121 are assigned to ASC payment group 2. The ASC facility service is the same whether the procedure is a screening or a diagnostic colonoscopy. If during the course of the screening colonoscopy performed at an ASC, 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 should be billed rather than code G0105. *Effective for services performed on or after January 1, 2007, a 25 percent coinsurance payment will apply for the colorectal cancer screening services (G0105 and G0121).*