CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4153	**Date: October 26, 2018**
	Change Request 10937

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

I. SUMMARY OF CHANGES: This instruction implements the payment methodology for discontinued procedures, HCPCS codes 44388, 45378, G0105, and G0121 with a modifier 53 for CAH Method II providers.

EFFECTIVE DATE: April 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2019

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
N	4/250/250.18/Incomplete Colonoscopies (Codes 44388, 45378, G0105 and G0121)

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4153	Date: October 26, 2018	Change Request: 10937

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

EFFECTIVE DATE: April 1, 2019
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I. GENERAL INFORMATION

A. 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.

Prior to calendar year (CY) 2015, according to Current Procedural Terminology (CPT) instruction, 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 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, 45378-53, G0105-53, and G0121-53.

The Medicare physician fee schedule will have specific values for codes 44388-53, 45378-53, G0105-53, and G0121-53. 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 shall be consistent with payment methodologies currently in place as outlined in PUB. 100-04, chapter 12, section 30.1 and chapter 18, section 60.2. As such, instruct CAHs that elect Method II payment to 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.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10937.1	Contractors shall apply the incomplete colonoscopies MPFS rate amount when billed with the following: TOB: 85x (CAH Method II) REV: 096x, 097x or 098x HCPCS: 44388, 45378, G0105 or G0121 Modifier: 53	X				X				
10937.2	FISS shall apply the CAH Method II payment methodology. (Based on the lesser of the actual charge or the MPFS for modifier 53. Minus deductible and coinsurance *115 %.) TOB: 85x (CAH Method II) REV codes: 096x, 097x or 098x HCPCS codes: 44388, 45378, G0105 or G0121 Modifier: 53.					X				
10937.3	Contractors shall use the following claim adjustment reason code on the remittance advice notice for service lines for which they have applied the Incomplete Colonoscopies payment methodologies. 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.	X				X				
10937.4	Contractors shall use the group code “CO” contractual obligation, on the remittance advice notices when the incomplete colonoscopies payment methodologies are applied.	X				X				
10937.5	Contractors shall use the following message on the Medicare Summary Notice for claims for which MPFS methodology was applied.	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	30.1 The approved amount is based on a special payment method. OR 30.1 La cantidad aprobada está basada en un método especial de pago.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10937.6	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cindy Pitts, Cindy.Pitts@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 04 – Part B Hospital (Including Inpatient Hospital part B and OPPS)

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(Rev.4153, Issued: 10-26-18)

Transmittals for Chapter 04

250.18 - Incomplete Colonoscopies (Codes 44388, 45378, G0105 and G0121)

250.18 Incomplete Colonoscopies (Codes 44388, 45378, G0105 and G0121)

(Rev. 4153, Issued: 10-26-18, Effective: 04-01-19, Implementation: 04-01-19)

An incomplete colonoscopy, e.g., the inability to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, is billed and paid using colonoscopy through stoma code 44388, colonoscopy code 45378, and screening colonoscopy codes G0105 and G0121 with modifier "-53." (Code 44388 is valid with modifier 53 beginning January 1, 2016.) The Medicare physician fee schedule database has specific values for codes 44388-53, 45378-53, G0105-53 and G0121-53. An incomplete colonoscopy performed prior to January 1, 2016, is paid at the same rate as a sigmoidoscopy. Beginning January 1, 2016, Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

As such, instruct CAHs that elect Method II payment to use modifier "-53" to identify an incomplete screening colonoscopy (physician professional service(s) billed in revenue code 096X, 097X, and/or 098X).

CAH Method II shall be consistent with the guidelines outlined in PUB. 100-04, chapter 12, section 30.1 and chapter 18, section 60.2.