



Related MLN Matters Article #: MM5387

Date Posted: January 23, 2007

Related CR #: 5387

Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change

Key Words

MM5387, CR5387, R1160CP, Colorectal, Cancer, Screening, Sigmoidoscopy, Colonoscopy

Provider Types Affected

Non-Outpatient Prospective Payment System (non-OPPS) hospital outpatient departments and Ambulatory Surgical Centers (ASCs) who bill Medicare fiscal intermediaries (FIs), carriers, or Part A/B Medicare Administrative Contractors (A/B MACs) for colorectal cancer screening flexible sigmoidoscopy and colonoscopy

Key Points

- The effective date of the instruction is January 1, 2007.
- The implementation date is July 2, 2007.

Sigmoidoscopies

- Section 1834(d)(2) of the Social Security Act imposes a 25% beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies (*Healthcare Common Procedure Coding System (HCPCS) code G0104-Colorectal cancer screening; flexible sigmoidoscopy*) that are performed in hospital outpatient departments.
- This coinsurance has already been applied in the Outpatient Prospective Payment System (OPPS) for OPPS hospitals (effective for services performed on or after January 1, 1999), and it will now be applied to non-OPPS hospitals, effective January 1, 2007.

Colonoscopies

- Section 1834(d)(3) of the Social Security Act, in part, imposes a 25% beneficiary coinsurance for colorectal cancer screening colonoscopies (*HCPCS codes G0105 - Colorectal cancer screening; colonoscopy on individual at high risk, and G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk*) that are performed in Ambulatory Surgical Centers (ASCs) and in hospital outpatient departments.

- This coinsurance has already been applied in the OPPTS for OPPTS hospitals (effective for services performed on or after January 1, 1999), and it is being applied to these services performed in ASCs or non-OPPTS hospitals, effective January 1, 2007.

Effective for services on or after January 1, 2007 (as is currently done for OPPTS hospitals), FIs, carriers, and A/B MACs will apply the 25% coinsurance to colorectal cancer screening flexible sigmoidoscopies (G0104) and colonoscopies (G0105 and G0121) that are performed in non-OPPTS hospitals and to colorectal cancer screening colonoscopies (HCPCS codes G0105 and G0121) that are performed in ASCs.

Details Included in CR5387

- For services beginning January 1, 2007, FIs, carriers, and A/B MACS will base the coinsurance amounts for colorectal screening sigmoidoscopies and colonoscopies, performed in non-OPPTS hospitals, on the payment methodology currently in place for colorectal screening services and on Medicare's ASC facility payment for services for colorectal cancer screening colonoscopies performed in ASCs.
- FIs, carriers, and A/B MACs will neither search for nor adjust claims for colorectal screening colonoscopies and sigmoidoscopies that have been paid prior to the implementation of this change by Medicare on July 2, 2007, but they will adjust such claims that are brought to their attention.
- While prior to January 1, 2007, both a deductible and a coinsurance applied to these colorectal screening procedures, effective for services on or after January 1, 2007 (as part of Section 5113 of the Deficit Reduction Act [DRA]), the deductible is waived for colorectal screening sigmoidoscopies and colonoscopies performed in ASCs or hospital outpatient departments. (This change is implemented under CR5127, transmittal 1004, dated July 21, 2006. A related *MLN Matters*, MM5127, is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf> on the CMS website.)
- For procedures performed in ASCs, this change applies to the ASC bills, not to the physician bills.
- FIs, carriers, and A/B MACs will change the Medicare Summary Notices MSNs issued to beneficiaries to reflect this change in the coinsurance/copayment amount. They will use MSN message 61.41 – "You pay 25% of the Medicare-approved amount for this service."

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf> on the CMS website.

The official instruction (CR5387) regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1160CP.pdf> on the CMS website.

Attached to the CR5387, providers will find the following updates to the *Medicare Claims Processing Manual* (Publication 100-04):

- Chapter 1 (General Billing Requirements), Section 30.3.1 (Mandatory Assignment on Carrier Claims); Chapter 14 (Ambulatory Surgical Centers), Section 40.2 (Carrier Adjustment of Base Payment Rates); and

- Chapter 18 (Preventive and Screening Services), Sections 60.1 (Payment), 60.1.1 (Deductible and Coinsurance); and 60.2.2 (Ambulatory Surgical Center [ASC] Facility Fee).

If providers have any questions, they may contact their carrier, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.