Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting http://www.cms.hhs.gov/http://www.cms.gov/NationalProvIdentStand / on the CMS website.

MLN Matters Number: MM5387 Revised
Related Change Request (CR) #: 5387
Related CR Release Date: January 19, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R1160CP
Implementation Date: July 2, 2007

Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change

Note: This article was updated on August 24, 2012, to reflect current Web addresses.This article was also revised ton January 26, 2007, to correct an effective date in the text (The effective date is January 1, 2007.) Also, the notice to beneficiaries mentioned on page 3 is the Medicare Summary Notice. All other information is the same.

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.

Impact on Providers

Effective for services on or after January 1, 2007, Medicare requires:

A 25% beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies, and colonoscopies performed in the outpatient departments of non-Outpatient Prospective Payment System (non-OPPS) hospitals; and

A 25% beneficiary coinsurance for colorectal cancer screening colonoscopies performed in ambulatory surgery centers (ASC).

Background

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. While 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), it will now be applied to non-OPPS hospitals, effective January 1, 2007.

Similarly, 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. And while, as above, 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), it is being applied to these services performed in ASCs or non-OPPS hospitals, effective January 1, 2007.

Therefore, effective for services on or after January 1, 2007 (as is currently done for OPPS hospitals), FIs, Carriers, 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-OPPS hospitals and to colorectal cancer screening colonoscopies (HCPCS codes G0105 and G0121) that are performed in ASCs.

Pertinent details included in CR 5387 are:

For services beginning January 1, 2007, FIs, carriers, A/B MACS will base the coinsurance amounts for colorectal screening sigmoidoscopies and colonoscopies, performed in non-OPPS hospitals, on the payment methodology currently in place for colorectal screening services and, for those performed in ASCs, on Medicare's ASC facility payment for services.

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 CR

5127, transmittal 1004, dated July 21, 2006. A related *MLN Matters,* MM5127, is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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."

Additional Information

You can find more information about the change in the coinsurance payment amount for colorectal cancer screening flexible sigmoidoscopy and colonoscopy performed in hospital outpatient departments and ASCs, by going to CR 5387, located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1160CP.pdf on the CMS website. Attached to the CR5387, you will find updated 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 you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Flu Shot Reminder

It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because the flu viruses change each year. Encourage your Medicare patients who haven't already done so to get their annual flu shot and don't forget to immunize yourself and your staff. **Protect yourself, your patients, and your family and friends. Get Your Flu Shot**. **It's Not Too Late!** Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website: **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0667.pdf** on the CMS website.