



**News Flash** – Section 3401(a) of the Patient Protection and Affordable Care Act (PPACA) imposes a 0.25 percentage point reduction to the Inpatient Prospective Payment System (IPPS) hospital's market basket for fiscal year (FY) 2010, effective for discharges on or after April 1, 2010. The reduction to the market basket will affect IPPS rates for discharges occurring on or after April 1, 2010, through September 30, 2010. Likewise, Section 3401(c) of PPACA imposes a 0.25 percentage point reduction to the Long Term Care Hospital's (LTCH) market basket for FY 2010, effective for discharges on or after April 1, 2010. The reduction to the market basket will affect LTCH rates for discharges occurring on or after April 1, 2010, through September 30, 2010. Section 3401(d) of PPACA imposes a 0.25 percentage point reduction to the Inpatient Rehabilitation Facility market basket for FY 2010, effective for discharges on or after April 1, 2010. This reduction is also resulting in changes to the standard payment conversion factor, payment rates, and the outlier threshold amount.

MLN Matters® Number: MM6760

Related Change Request (CR) #: 6760

Related CR Release Date: April 28, 2010

Effective Date: October 1, 2010

Related CR Transmittal #: R1953CP

Implementation Date: October 4, 2010

## Use of 12X Type of Bill (TOB) for Billing Colorectal Screening Services

### Provider Types Affected

Hospitals that bill Medicare fiscal intermediaries (FI) or Medicare Administrative Contractors (A/B MAC) for colorectal screening services provided for hospital inpatients should be aware of this issue.

### What You Need to Know

CR 6760, from which this article is taken, requires you to use (effective October 1, 2010) 12X Type of Bill (TOB), in place of 13X TOB, to bill for colorectal screening services that you provide to hospital inpatients under Medicare Part B, or when Part A benefits have been exhausted. You should make sure that your billing staffs are aware of this new requirement.

### Background

Currently, you use TOB 13X to bill for colorectal screening services that you provide to hospital inpatients under Part B. CR 6760, from which this article is

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taken, announces that such services may be covered under Part B (TOB 12X), even though the patient has Part A coverage for the hospital stay, if applicable conditions of coverage are met and he/she has not exceeded applicable frequency limitations.

Specifically (effective for claims with dates of service of October 1, 2010 and later), you must use 12X TOB in place of 13X TOB to bill for colorectal screening services that you provide to hospital inpatients under Part B, or when Part A benefits have been exhausted. This applies for services that you bill using CPT codes 82270 (Fecal Occult Blood Test), G0104 (Flexible Sigmoidoscopy), G0105 (Colonoscopy (high risk)), G0106 (Barium Enema (*alternative to G0104*)), G0120 (Barium Enema (*alternative to G0105*)), G0121 (Colonoscopy (not high risk)), G0122 (Barium Enema (non-covered), or G0328 (Fecal Occult Blood Test (*alternative*)).

Please note that when billing for services to other than hospital inpatients, you should continue reporting appropriate TOBs: 13x, 14X, 22X, 23X, 83X, and 85X.

## Additional Information

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You can find CR 6760 at

<http://www.cms.gov/Transmittals/downloads/R1953CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section 60.6 (Billing Requirements for Claims Submitted to FIs) as an attachment to that CR.

If you have any questions, please contact your FI or MAC at their toll-free number, which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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