CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1217	**Date: MARCH 30, 2007**
	Change Request 5541

Subject: Update to Internet-Only-Manual (IOM) Publication 100-04, Chapter 18, Section 60.1

I. SUMMARY OF CHANGES: Publication 100-04, chapter 60, section 60.1 suggests that the requirement for annual Part B deductible for diagnostic colorectal services is waived. Section 5113 of the Deficit Reduction Act of 2005 waived the requirement for deductible for screening colorectal services, not diagnostic colorectal services. Part B deductible still applies to diagnostic colorectal services codes 45330, 45378, and 74280. This Change Request updates the manual to clarify the requirement for the annual Part B deductible for diagnostic colorectal services.

New / Revised Material
Effective Date: July 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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/60/60.1/Payment

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: 1217	Date: March 30 ,2007	Change Request: 5541

SUBJECT: Update to the Internet-Only-Manual (IOM) Publication 100-04, Chapter 18, Section 60.1

Effective Date: **July 1, 2007**

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: It has been brought to CMS' attention that Section 60.1 of Pub. 100-04, chapter 18, suggests that the requirement for annual Part B deductible for diagnostic colorectal services is waived. Section 5113 of the Deficit Reduction Act of 2005 waived the deductible for screening colorectal service codes G0104, G0105, G0106, G0120, and G0121 furnished on or after January 1, 2007. The annual Part B deductible still applies to diagnostic colorectal services codes 45330, 45378, and 74280. This Change Request (CR) updates the manual to clarify the requirement for the annual Part B deductible for diagnostic colorectal services.

B. Policy: No change in policy. This CR simply clarifies the application of deductible and coinsurance for diagnostic colorectal services codes 45330, 45378 and 74280.

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	
5541.1	Contractors shall note the revisions made to Pub 100-04, chapter 18, section 60.1.	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	
5541.2	A provider education article related to this instruction will be available at	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	
	http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will 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 1 week of the availability of the provider education article. In addition, the provider 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): Bill Ruiz, (410) 786-9283

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For TITLE XVIII Contractors,* use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****, use only one of the following statements:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does 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.

60.1 - Payment

(Rev.1217, Issued: 03-30-07, Effective: 07-01-07, 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 IHS hospitals when the service is billed on TOB 83x.

Prior to January 1, 2007, deductible and coinsurance apply to *HCPCS codes G0104, G0105, G0106, G0120, and G0121.* 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 *screening* services. Coinsurance still applies. *Coinsurance and deductible applies to the diagnostic colorectal service codes listed below.*

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 *and G0120*	74280

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 to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with CPT code 82270.