CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1953	**Date: April 28, 2010**
	Change Request 6760

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

I. SUMMARY OF CHANGES: Currently, 12X TOB is not a valid TOB for the billing of colorectal screening services when provided to hospital inpatients under Part B. Providers are currently billing for these services using TOB 13X. This instruction requires 12X TOB to be used in place of 13X TOB for the billing of colorectal screening services when provided to hospital inpatients under Part B or when Part A benefits have been exhausted. Appropriate TOBs for services other than hospital inpatients remain the same. They are 13X, 14X, 22X, 23X, 83X, and 85X.

EFFECTIVE DATE: October 1, 2010
IMPLEMENTATION DATE: October 4, 2010

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	18/60/60.6/Billing Requirements for Claims Submitted to FIs

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1953	Date: April 28, 2010	Change Request: 6760

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

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: Currently, 12X TOB is not a valid TOB for the billing of colorectal screening services when provided to hospital inpatients under Part B. Providers are currently billing for these services using TOB 13X. This instruction requires 12X TOB to be used in place of 13X TOB for the billing of colorectal screening services when provided to hospital inpatients under Part B or when Part A benefits have been exhausted. Appropriate TOBs for services other than hospital inpatients remain the same. They are 13X, 14X, 22X, 23X, 83X, and 85X.

B. Policy: Colorectal screening services when provided to an inpatient of a hospital 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 the applicable frequency limitations have not been exceeded by the patient.

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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6760.1	Effective with claims for dates of service October 1, 2010 and later, FIs shall instruct providers to report 12X TOB instead of 13X when submitting claims for screening colorectal services (codes 82270, G0104, G0105, G0106, G0120, G0121, and G0328) when provided to hospital inpatients under Part B or when Part A benefits have been exhausted.	X		X							
6760.2	Effective with claims for dates of service October 1, 2010 and later, FIs shall instruct providers to continue reporting appropriate TOBs: 13x, 14X, 22X, 23X, 83X, and 85X when billing for colorectal screening services to other than hospital inpatients under Part B or when Part A benefits have exhausted.	X		X							
6760.3	Effective with claims for dates of service October 1, 2010 and later, FISS and CWF shall modify any editing that currently exists on claims containing 12X TOB submitted	X					X			X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	during an inpatient stay (11X TOB) to allow the 12X TOB if the claim contains colorectal screening services.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6760.4	A provider education article related to this instruction will be available at 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.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

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

Section B: For all other recommendations and supporting information, use this space: None

V. CONTACTS

Pre-Implementation Contact(s): For FI Claims; Antoinette Johnson, antoinettte.johnson@cms.hhs.gov at 410-786-9326 and William Ruiz, william.ruiz@cms.hhs.gov at 410-786-9283.

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

60.6 - Billing Requirements for Claims Submitted to FIs

(Rev.1953, Issued: 04-28-10, Effective: 10-01-10, Implementation: 10-04-10)

Follow the general bill review instructions in Chapter 25. Hospitals use the ANSI X12N 837I to bill the FI or on the hardcopy Form CMS-1450. Hospitals bill revenue codes and HCPCS codes as follows:

Screening Test/Procedure	Revenue Code	HCPCS Code	TOB
Fecal Occult blood test	030X	82270*** (G0107***), G0328	*12X*, 13X, 14X**, 22X, 23X, 83X, 85X
Barium enema	032X	G0106, G0120, G0122	*12X*, 13X, 22X, 23X, 85X****
Flexible Sigmoidoscopy	*	G0104	*12X*, 13X, 22X, 23X, 83X, 85X****
Colonoscopy-high risk	*	G0105, G0121	*12X*, 13X, 22X, 23X, 83X, 85X****

* The appropriate revenue code when reporting any other surgical procedure.

** 14X is only applicable for non-patient laboratory specimens.

*** 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.

**** CAHs that elect Method II bill revenue code 096X, 097X, and/or 098X for professional services and 075X (or other appropriate revenue code) for the technical or facility component.

Special Billing Instructions for Hospital Inpatients

When these tests/procedures are provided to inpatients of a hospital *or when Part A benefits have been exhausted*, they are covered under this benefit. However, the provider bills on bill type *12X* using the discharge date of the hospital stay to avoid editing in the Common Working File (CWF) as a result of the hospital bundling rules.