Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

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(Rev. 13677; Issued: 03-12-26)

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Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Infection Prevention	G0011	Individual counseling for pre-exposure prophylaxis (PrEP) by physician or QHP to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence, 15-30 minutes	**B**	WAIVED
	G0012	Injection of pre-exposure prophylaxis (prep) drug for hiv prevention, under skin or into muscle, Short Descriptor: Inj, prep drug for hiv prev		
	G0013	Individual counseling for pre-exposure prophylaxis (PrEP) by clinical staff to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence		
	J0739	Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv) Short Descriptor: Injection, cabotegravir, 1 mg		
	J0750	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv), Short Descriptor: Hiv prep, ftc/tdf 200/300mg		

	J0751	Emtricitabine 200mg and tenofovir alafenamide 25mg, oral, fda approved prescription, only for use as pre-exposure prophylaxis (not for use as treatment of hiv), Short Descriptor: Hiv prep, ftc/tad 200/25mg		
	J0799	FDA approved prescription drug, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv), not otherwise classified, Short Descriptor: Hiv prep, fda approved, noc		
	Q0516	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 30-days, Short Descriptor: Supply fee hiv prep oral 30-days		
	Q0517	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 60-days, Short Descriptor: Supply fee hiv prep oral 60-days		
	Q0518	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 90-days, Short Descriptor: Supply fee hiv prep oral 90-days		
	Q0519	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 30-days, Short Descriptor: Supply fee hiv prep inj 30		
	Q0520	Pharmacy supplying fee		

		for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 60-days, Short Descriptor: Supply fee hiv prep inj 60		
	Q0521	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription, Short descriptor: Supply fee hiv prep fda appr		

1.3 - Waiver of Cost Sharing Requirements of Coinsurance, Copayment and Deductible for Furnished Preventive Services Available in Medicare

(Rev. 2233, Issued: 05-27-11, Effective: 01-01-11, Implementation: 06-28-11)

Section 4104(b)(4) of the ACA, amends section 1833(a)(1) of the Act, by requiring 100 percent payment for the IPPE, AWV and for those preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

Waiver of Coinsurance and Copayment for Preventive Services and Screenings

This requirement waives any coinsurance or copayment that would otherwise be applicable under section 1833(a)(1) of the Act for those items and services listed in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the USPSTF has given a grade of A or B. In addition, section 4103(c)(1) of the Affordable Care Act waives the coinsurance or copayment for the AWV.

The coinsurance or copayment represents the beneficiary's share of the payment to the provider or supplier for furnished services. Coinsurance generally refers to a percentage (for example, 20 percent) of the Medicare payment rate for which the beneficiary is liable and is applicable under the PFS, while copayment generally refers to an established amount that the beneficiary must pay that is not necessarily related to a particular percentage of the Medicare payment, and is applicable under the hospital Outpatient Prospective Payment System (OPPS).

Waiver of Deductible for Preventive Services and Screening

Section 4104(b)of the Affordable Care Act amends section 1833(b)(1) of the Act to waive the deductible for preventive services described in subparagraph (A) of section 1861(ddd)(3) of the Act that have a grade of A or B from the USPSTF. In addition, section 4103(c)(1) of the Affordable Care Act waives the deductible for the AWV. These provisions are effective for services furnished on and after January 1, 2011. Section 101(b)(2) of the MIPPA amended section 1833(b) of the Act to waive the deductible for the IPPE effective January 1, 2009.

NOTE: Not all preventive services allowed in Medicare and recommended by the USPSTF have a Grade of A or B, and therefore, some of the preventive services do not meet the criteria in sections 1833(a)(1) and (b)(1) of the Act for the waiver of deductible and coinsurance. Refer to the Preventive Services Table in section 5.2, of this section, for specific USPSTF ratings for preventive services.

10 - Pneumococcal Pneumonia, Influenza Virus, Hepatitis B, and Coronavirus Disease (COVID-19) Vaccines and Administration

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

For MACs (Part B), Part B of Medicare pays 100 percent of the Medicare allowed amount for pneumococcal, influenza, hepatitis B virus COVID-19 vaccines and their administration.

Part B deductible and coinsurance do not apply for pneumococcal, influenza, hepatitis virus and/or COVID-19 vaccine.

State laws governing who may administer preventive vaccinations and the coronavirus vaccines as well as how the vaccines are transported vary widely. Medicare contractors should instruct physicians, suppliers, and providers to become familiar with state regulations for all vaccines in the areas where they will be immunizing.

10.1 - Coverage Requirements

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

Pneumococcal, influenza virus, hepatitis B, and COVID-19 vaccines and their administration are covered only under Medicare Part B, regardless of the setting in which they are furnished, even when provided to an inpatient during a hospital stay covered under Part A.

See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, for additional coverage requirements for pneumococcal, hepatitis B, influenza virus, and COVID-19 vaccinations.

10.1.1 - Pneumococcal Vaccine

(Rev. 3159, Issued: 12-31-14, Effective: 09-19-14, Implementation: 02-02-15)

Section 1861(s)(10)(A) of the Social Security Act and regulations at 42 CFR 410.57 authorize Medicare coverage under Part B for pneumococcal vaccine and its administration. Medicare does not require for coverage purposes, that a doctor of medicine or osteopathy order the pneumococcal vaccine and its administration. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 50.4.4.2 for complete coverage requirements for pneumococcal vaccine.

10.1.2 - Influenza Virus Vaccine
(Rev. 2253, Issued: 07-08-11, Effective: 08-08-11, Implementation: 08-08-11)

Effective for services furnished on or after May 1, 1993, the influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law. Typically, this vaccine is administered once a flu season. Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the vaccine. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision. Since there is no yearly limit, A/B MACs (A) and (B) determine whether such services are reasonable and allow payment if appropriate.

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.4.2 for additional coverage requirements for influenza virus vaccine.

10.1.3 - Hepatitis B Vaccine
(Rev. 13091; Issued:02-21-25; Effective: 01-01-25; Implementation: 07-07-25)

Effective for services furnished on or after September 1, 1984, the hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B, e.g., exposed to hepatitis B**.** Effective January 1, 2025, a doctor's order will no longer be necessary for the administration of a hepatitis B vaccine under Part B. Therefore, mass immunizers can use the roster billing process to submit Medicare Part B claims for hepatitis B vaccines and their administration.

10.1.4 – COVID-19 Vaccine
(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The COVID-19 vaccine and its administration are covered when furnished in compliance with any applicable State law. Effective dates for each COVID-19 vaccine can be found at https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies.

The COVID-19 vaccine is administered according to manufacturer's recommendations for each specific vaccine during the public health emergency declared in 2020. This recommendation is subject to change.

10.2 - Billing Requirements
(Rev. 13547; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

A. Edits Not Applicable to Claims for Pneumococcal, Influenza, Hepatitis B or COVID-19 Vaccines and Administration

The Common Working File (CWF) and shared systems bypass all Medicare Secondary Payer (MSP) utilization edits in CWF on all claims when the only service provided is pneumococcal, influenza, hepatitis B or COVID-19 vaccine and/or their administration. This waiver does not apply when other services, (e.g., office visits), are billed on the same claim as pneumococcal, influenza, hepatitis B or COVID-19 vaccinations. If the provider knows, or has reason to believe that a particular group health plan covers preventive vaccines and their administration, and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

First claim development alerts from CWF are not generated for pneumococcal, influenza, hepatitis B or COVID-19 vaccine. However, first claim development is performed if other services are submitted along with pneumococcal, influenza, hepatitis B or COVID-19 vaccines.

See Pub. 100-05, Medicare Secondary Payer Manual, chapters 4 and 5, for responsibilities for MSP development where applicable.

B Institutional Claims

Chapter 25 of this manual provides general billing instructions that must be followed for institutional claims.

The following "providers of services" may administer and submit institutional claims to the A/B MACs (A) for these vaccines:

Hospitals;

Critical Access Hospitals (CAHs);

Skilled Nursing Facilities (SNFs);

Home Health Agencies (HHAs);

Hospices;

Comprehensive Outpatient Rehabilitation Facilities (CORFs);

Indian Health Service (IHS)/Tribally owned and/or operated hospitals and hospital-based facilities; and

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), effective for dates of service on or after July 1, 2025.

Other billing entities that may submit institutional claims are:

Independent Renal Dialysis Facilities (RDFs).

Effective for dates of service on or after July 1, 2025, RHCs and FQHCs shall submit institutional claims for pneumococcal, influenza, hepatitis B and COVID-19 vaccinations, with or without a visit/encounter or qualifying visit on the same day. (See §10.2.2.2 of

this chapter for special instructions for independent RHCs and freestanding FQHCs.)

Institutional providers should bill for the vaccines and their administration on the same bill. Separate bills for vaccines and their administration are not required. The only exceptions to this rule occur when the vaccine is administered during the course of an otherwise covered home health visit since the vaccine, or its administration is not included in the visit charge. (See §10.2.3 of this chapter).

C Professional Claims

Billing for Additional Services

If a physician sees a beneficiary for the sole purpose of administering a Medicare covered preventive vaccine, they may not routinely bill for an office visit. However, if the beneficiary actually receives other services constituting an "office visit" level of service, the physician may bill for a visit in addition to the vaccines and their administration, and Medicare will pay for the visit in addition to the vaccines and their administration if it is reasonable and medically necessary.

Nonparticipating Physicians and Suppliers

Nonparticipating physicians and suppliers (including local health facilities) that do not accept assignment may collect payment from the beneficiary for the administration of the vaccines, but must submit an unassigned claim on the beneficiary's behalf. Effective for claims with dates of service on or after February 1, 2001, per §114 of the Benefits Improvement and Protection Act of 2000, all drugs and biologicals must be paid based on mandatory assignment. Therefore, regardless of whether the physician and supplier usually accept assignment, they must accept assignment for the vaccines, may not collect any fee up front, and must submit the claim for the beneficiary.

Entities, such as local health facilities, that have never submitted Medicare claims must obtain a National Provider Identifier (NPI) for Part B billing purposes.

Separate Claims for Vaccines and Their Administration

In situations in which the vaccine and the administration are furnished by two different entities, the entities should submit separate claims. For example, a supplier (e.g., a pharmacist) may bill separately for the vaccine, using the Healthcare Common Procedure Coding System (HCPCS) code for the vaccine, and the physician or supplier (e.g., a drugstore) who actually administers the vaccine may bill separately for the administration, using the HCPCS code for the administration. This procedure results in contractors receiving two claims, one for the vaccine and one for its administration.

For example, when billing for influenza virus vaccine administration only, billers should list only HCPCS code G0008 in block 24D of the Form CMS-1500. When billing for the influenza virus vaccine only, billers should list only HCPCS code 90658 in block 24D of the Form CMS-1500. The same applies for the other Medicare covered preventive vaccinations.

In situations such as a public health emergency when vaccines are supplied at no charge to providers, entities shall submit claims for the administration of the vaccine only. For example, a provider or supplier may only submit a claim for the HCPCS code for the administration of the vaccine. If the billing systems providers and suppliers use will not allow submission of only the vaccine or only the administration, $.01 should be submitted as the charge for the service that was not provided.

The contractor shall deny claims for vaccine reimbursement costs when the vaccine has been provided at no charge to providers and suppliers.

10.2.1 - Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes

(Rev. 13677; Issued: 03-12-2026; Effective: 04-13-2026; Implementation: 04-13-2026)

Vaccines and their administration are reported using separate codes. The following codes are for reporting the vaccines only.

HCPC	Definition
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use
90654	Influenza virus vaccine, split virus, preservative-free, for intradermal use, for adults ages 18 – 64;
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use;
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use;
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use;
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use;
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use
90672	Influenza virus vaccine, live, quadrivalent, for intranasal use
90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use

90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated,
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for us in individuals 2 years or older, for subcutaneous or intramuscular use;
90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use;
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use;
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use;
90746	Hepatitis B vaccine, adult dosage, for intramuscular use; and
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use
90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg

Note: COVID-19 vaccine and administration HCPCS are temporarily posted at: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies.

Note: For the Medicare-covered codes for the influenza vaccines approved by the Food and Drug Administration (FDA) for the current influenza vaccine season, please go to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html

The following codes are for reporting administration of the vaccines only. The administration of the vaccines is billed using:

*** NOTE:** Beginning January 1, 2011, providers should report G0010 for billing under the OPPS rather than 90471 or 90472 to ensure correct waiver of coinsurance and deductible for the administration of hepatitis B vaccine.

NOTE: COVID-19 vaccine and administration HCPCS are temporarily posted at: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/COVID-19-vaccines-and-monoclonal-antibodies.

The following diagnosis code must be reported. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim, the applicable following diagnosis code may be used.

ICD-10-CM Diagnosis Code	Description
Z23	Encounter for Immunization

NOTE: ICD-10-CM diagnosis code Z23 is to be used for all encounters for preventive vaccine immunizations, including COVID-19 immunizations.

The following condition code must be reported on institutional claims when diagnosis code Z23 is required for a vaccination.

Condition Code	***Description***
A6	*Vaccine / Medicare 100% Payment*

All claims must have the appropriate diagnosis code, procedure, and admin code to process correctly.

10.2.1.1 – Claims Received with Missing Data

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

If a diagnosis code for a pneumococcus, hepatitis B, influenza virus, or COVID-19 vaccination is not reported on a claim, contractors may enter the diagnosis on the claim and continue to process the claim for payment.

If the diagnosis code and the narrative description are correct, but the HCPCS code is incorrect, the MACs (Part A or Part B) may correct the HCPCS code and pay the claim. For example, if the reported diagnosis code is Z23 and the narrative description (if annotated on the claim) says "flu shot" but the HCPCS code is incorrect, contractors may change the HCPCS code and pay for the flu vaccine. Effective October 1, 2006, A/B MACs (B) should follow the instructions in Pub. 100-04, Chapter 1, Section

- (MAC (Part B) Data Element Requirements) for claims submitted without a HCPCS code.

Claims for hepatitis B vaccinations must report the NPI number of the referring physician. In addition, if a doctor of medicine or osteopathy does not order the influenza virus vaccine, the MACs (Part A) claims require:

- The provider's own NPI to be reported in the NPI field for the attending physician.

10.2.2 - Claims Submitted to MACs Using Institutional Formats

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The applicable types of bill acceptable when billing for influenza virus, pneumococcal and COVID-19 vaccines are 012x, 013x, 022x, 023x, 034x, 072x, 075x, 081x, 082x, and 085x. Contractors shall refer to § 10.3.2 for applicable billing requirements for mass immunization.

The following revenue codes are used for reporting vaccines and administration of the vaccines for all providers except RHCs and FQHCs. Independent and provider based RHCs and FQHCs follow §10.2.2.2 below when billing for influenza virus, pneumococcal, hepatitis B, and COVID-19 vaccines.

Units and HCPCS codes are required with revenue code 0636:

Revenue Code	Description
0636	Pharmacy, Drugs requiring detailed coding (a)
0771	Preventive Care Services, Vaccine Administration

In addition, for the influenza virus vaccine, providers report condition code M1 when roster billing. See roster billing instructions in §10.3 of this chapter.

When vaccines are provided to inpatients of a hospital or SNF, they are covered under the vaccine benefit. However, the hospital bills on type of bill 012x using the discharge date of the hospital stay or the date benefits are exhausted. A SNF submits type of bill 022x for its Part A inpatients.

10.2.2.1 - Payment for Pneumococcal Pneumonia Virus, Influenza Virus, Hepatitis B Virus and COVID-19 Vaccines and Their Administration on Institutional Claims

(Rev. 13547; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

Payment for Vaccines

Payment for these vaccines is as follows:

Facility	Type of Bill	Payment
Hospitals, other than Indian Health Service (IHS) Hospitals, IHS CAHs, and Critical Access Hospitals (CAHs)	012x, 013x	Reasonable cost
IHS Hospitals	012x, 013x	95% of the AWP

IHS CAHs	012x, 085x	95% of the AWP
CAHs Method I and Method II (other than professional revenue codes)	012x, 085x	Reasonable cost
Skilled Nursing Facilities	022x, 023x	Reasonable cost
Home Health Agencies	034x	Reasonable cost
Hospices	081x, 082x	95% of the AWP
Comprehensive Outpatient Rehabilitation Facilities	075x	95% of the AWP
Independent Renal Dialysis Facilities (RDFs)	072x	95% of the AWP
Hospital-based Renal Dialysis Facilities (RDFs)	072x	Reasonable cost
Rural Health Clinics (RHCs)	71x	95% of the AWP (effective for dates of service on or after July 1, 2025) then subsequently settled through the cost report.
Federally Qualified Health Centers (FQHCs)	77x	95% of the AWP (effective for dates of service on or after July 1, 2025) then subsequently settled through the cost report.

Payment for Vaccine Administration

Payment for the administration of pneumococcal, influenza, hepatitis B and COVID-19 vaccines is as follows:

Facility	**Type of Bill**	**Payment**

Hospitals, other than IHS Hospitals, IHS CAHs, and CAHs	012x, 013x	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS
IHS Hospitals	012x, 013x	MPFS
IHS CAHs	012x, 085x	MPFS
CAHs Method I and Method II (other than professional revenue codes)	012x, 085x	Reasonable cost
CAHs Method II (Professional Revenue Codes 096x, 097x, 098x)	085x	MPFS
Skilled Nursing Facilities	022x, 023x	MPFS
Home Health Agencies	034x	OPPS
Hospices	081x, 082x	MPFS
Comprehensive Outpatient Rehabilitation Facilities	075x	MPFS
Independent RDFs	072x	MPFS
Hospital-based RDFs	072x	Reasonable cost
Rural Health Clinics (RHCs)	71x	National Fee Schedule for Vaccine Administration (effective for dates of service on or after July 1, 2025)
Federally Qualified Health Centers (FQHCs)	77x	National Fee Schedule for Vaccine Administration (effective for dates of service on or after July 1, 2025)

10.2.2.2 - Special Instructions for Independent and Provider-Based Rural Health Clinics/Federally Qualified Health Center (RHCs/FQHCs) Clinics/Federally Qualified Health Center (RHCs/FQHCs)

(Rev. 13547; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

Prior to July 1, 2025, pneumococcal, influenza and COVID-19 vaccines and their

administration did not count as RHC/FQHC visits. The cost for these vaccines and their administration was included in the cost report and a visit was not billed for these services. RHCs did not report vaccines on the claim, TOB 71x. However, for FQHCs, if there was another reason for the visit, the vaccine and the administration code would be reported on the claim, TOB 77x, for informational and data collection purposes only. Coinsurance and deductible did not apply to these vaccines.

Prior to January 1, 2025, payment for the hepatitis B vaccine was included in the RHC all- inclusive and FQHC PPS rate. RHCs/FQHCs did not bill for a visit when the only service involved was the administration of the hepatitis B vaccine. However, the charges of the vaccine and its administration could be included in the line item for the otherwise qualifying visit. A visit could not be billed if vaccine administration was the only service the RHC/FQHC provides.

Effective January 1, 2025 through June 30, 2025, payment for the hepatitis B vaccine and its administration is through the cost report and no longer included in the RHC all-inclusive and FQHC PPS rate. The cost for these vaccines and their administration is included in the cost report and a visit is not billed for these services. RHCs do not report vaccines on the claim, TOB 71x. However, for FQHCs, if there was another reason for the visit, the vaccine and the administration code should be reported on the claim, TOB 77x, for informational and data collection purposes only. Coinsurance and deductible do not apply to these vaccines.

Effective for dates of service on or after July 1, 2025, RHCs (bill type 71x) and FQHCs (bill type 77x), shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, hepatitis B and COVID-19 -- on the claim. A visit/encounter is not required for these services; however, if reported on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance and deductible do not apply to these vaccines. Although paid at the time of service, payments for these services must be annually reconciled with the RHC or FQHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Note: An additional payment for influenza, pneumococcal, hepatitis B, COVID-19 vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for RHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E and Pub. 100-04 for more information.

10.2.3 - Institutional Claims Submitted by Home Health Agencies and Hospices

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The following provides billing instructions for Home Health Agencies (HHAs) in various situations:

Where the sole purpose for an HHA visit is to administer a vaccine (influenza virus, pneumococcal, hepatitis B or COVID-19), Medicare will not pay for a skilled nursing visit by an HHA nurse under the HHA benefit. However, the vaccine and its administration are

covered under the vaccine benefit. The administration should include charges only for the supplies being used and the cost of the injection. Medicare does not allow HHAs to charge for travel time or other expenses (e.g., gasoline). In this situation, the HHA bills under bill type 034x and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

NOTE: A separate bill is not allowed for the visit.

If a vaccine (influenza virus, pneumococcal, hepatitis B, or COVID-19) is administered during the course of an otherwise covered home health visit (e.g., to perform wound care), the visit would be covered as normal but the HHA must not include the vaccine or its administration in their visit charge. In this case, the HHA is entitled to payment for the vaccine and its administration under the vaccine benefit. In this situation, the HHA bills under bill type 034x and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

NOTE: A separate bill is required for the visit

Where a beneficiary does **not** meet the eligibility criteria for home health coverage, a home health nurse may be paid for the vaccine (influenza virus, pneumococcal, hepatitis B or COVID-19) and its administration. No skilled nursing visit charge is billable. Administration of the services should include charges only for the supplies being used and the cost of the injection. Medicare does not pay for travel time or other expenses (e.g., gasoline). In this situation, the HHA bills under bill type 034x and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

If a beneficiary meets the eligibility criteria for coverage, but his or her spouse does not, and the spouse wants an injection the same time as a nursing visit, HHAs bill in accordance with the last bullet point above.

The following provides billing instructions for hospices:

Hospices can provide the influenza virus, pneumococcal, hepatitis B and COVID-19 vaccines to those beneficiaries who request them, including those who have elected the hospice benefit. These services may be covered when furnished by the hospice.

For dates of service before October 1, 2016, services for vaccines and their administration provided by a hospice should be billed on a professional claim to the local MAC. Payment is made using the same methodology as if they were a supplier. Hospices that do not have a supplier number should contact their MAC to obtain one in order to bill for these benefits.

For dates of service on or after October 1, 2016, services for vaccines and their administration provided by a hospice may be billed on an institutional claim.

10.2.4 - Payment Procedures for Renal Dialysis Facilities (RDF)
(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

MACs processing institutional claims pay for pneumococcal, influenza virus, hepatitis B and COVID-19 vaccines for freestanding RDFs based on the lower of the actual charge or 95 percent of the average wholesale price and based on reasonable cost for provider- based RDFs. Deductible and coinsurance do not apply for pneumococcal, influenza virus, hepatitis B and COVID-19 vaccines. MACs must contact their professional claims processing staff to obtain information in order to make payment for the administration of these vaccines.

10.2.4.1 - Hepatitis B Vaccine Furnished to ESRD Patients
(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

Hepatitis B vaccine and its administration (including staff time and supplies such as syringes) are paid to ESRD facilities in addition to, and separately from, the dialysis composite rate payment.

Payment for the hepatitis B vaccine for ESRD patients follows the same general principles that are applicable to any injectable drug or biological. Hospital-based facilities are paid for their direct and indirect costs on a reasonable cost basis, and independent facilities are paid the lower of the actual charge or 95 percent of the AWP. The allowance for an injectable is based on the cost of the injectable and any supplies used for administration, plus a maximum $2 for the labor involved, if the facility's staff administers the vaccine. In addition, the MAC (Part A) makes an appropriate allowance for facility overhead.

Where the vaccine is administered in a hospital outpatient department for home dialysis patients or for patients with chronic renal failure (but not yet on dialysis), payment is on a reasonable cost basis. Outpatient hospital vaccines for non-dialysis purposes are paid under hospital outpatient PPS rules.

10.2.5 - Claims Submitted to MACs (Part B)
(Rev. 13091; Issued:02-21-25; Effective: 01-01-25; Implementation: 07-07-25)

Medicare does not require that the influenza virus, pneumococcal, hepatitis B, or COVID-19 vaccine be administered under a physician's order or supervision.

A. Reporting Specialty Code/Place of Service (POS) to CWF Specialty

MACs (Part B) use specialty code 60 (Public Health or Welfare Agencies (Federal, State, and Local)) for Public Health Service Clinics (PHCs).
MACs (Part B) use specialty code 73 (Mass Immunization Roster Billers) for specialty code C1 centralized billers and specialty code A5 for pharmacies (all other suppliers (drug stores, department stores)).
Entities and individuals other than PHCs and pharmacies use the CMS specialty code that best defines their provider type. A list of specialty codes can be found in Pub. 100-04, Chapter 26. The CMS specialty code 99 (Unknown Physician Specialty) is acceptable where no other code fits.

Place of Service (POS)
State or local PHCs use POS code 71 (State or Local Public Health Clinic). POS 71 is not used for individual offices/entities other than PHCs (e.g., a mobile unit that is non-PHC affiliated should use POS 99). Preprinted Form CMS-1500s (08-05) used for simplified roster billing should show POS 60 (Mass Immunization Center) regardless of the site where vaccines are given (e.g., a PHC or physician's office that roster claims should use POS 60). Individuals/entities administering influenza virus, pneumococcal, hepatitis B, and COVID-19 vaccinations in a mass immunization setting (including centralized billers), regardless of the site where vaccines are given, should use POS 60 for roster claims, paper claims, and electronically filed claims.
Normal POS codes should be used in other situations.
Providers use POS 99 (Other Unlisted Facility) if no other POS code applies.

10.2.5.1 - MAC (Part B) Indicators for the Common Working File (CWF)
(Rev. 11362; Issued: 04-22-22; Effective: 01-11-22; Implementation:07-05-22)

The MAC (Part B) record submitted to CWF must contain the following indicators:

Description	Payment Indicator	Payment	Deductible Indicator	Deductible	Type of Service
Pneumococcal	"1"	100 percent	"1"	Zero deductible	"V"
Influenza	"1"	100 percent	"1"	Zero deductible	"V"
Hepatitis B	"1"	100 percent	"1"	Zero deductible	"9"
COVID-19	"1"	100 percent	"1"	Zero deductible	"V"

A payment indicator of "1" represents 100 percent payment. A deductible indicator of "1" represents a zero deductible. A payment indicator of "0" represents 80 percent payment. A deductible indicator of "0" indicates that a deductible applies to the claim.

The record must also contain a "V" in the type of service field, which indicates that this is a pneumococcal, influenza virus, or COVID-19 vaccine. MACs (Part B) use a "1" in the type of service field, which indicates medical care for a hepatitis B vaccine.

10.2.5.2 - MAC (Part B) Payment Requirements

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

Payment for Medicare covered preventive vaccines, including the recently developed COVID-19 vaccines, follows the same standard rules that are applicable to any injectable drug or biological.

Effective for claims with dates of service on or after February 1, 2001, §114, of the Benefits Improvement and Protection Act of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, all providers of Medicare covered preventive vaccines, must accept assignment for the vaccine.

Prior to March 1, 2003, the administration of pneumococcal, influenza virus, and hepatitis B vaccines, (HCPCS codes G0008, G0009, and G0010), though not reimbursed directly through the MPFS, were paid at the same rate as HCPCS code 90782 on the MPFS for the year that corresponded to the date of service of the claim.

For dates of service on or after March 1, 2003 through December 31, 2021, payment rates for HCPCS G0008, G0009, and G0010 were paid at the same rate as similar services on the MPFS determined through notice-and-comment rulemaking. These payment amounts were determined on an annual basis and MACs were notified accordingly.

Beginning January 1, 2022, the national payment rate for HCPCS G0008, G0009, and G0010 is $30. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for HCPCS G0008, G0009, and G0010 are available of the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing

Beginning January 1, 2022 and through the end of the calendar year in which the PHE for COVID-19 ends, the national payment rate for the administration of COVID-19 vaccines is $40. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for the administration of COVID-19 vaccines are available of the CMS website: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies

Effective January 1 of the year following the year in which the PHE for COVID-19 ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines.

Assignment for the administration is not mandatory, but is applicable should the provider be enrolled as a provider type "Mass Immunization Roster Biller," submits roster bills, or participates in the centralized billing program.

MACs (Part B) may not apply the limiting charge provision for pneumococcal, influenza virus , hepatitis B, or COVID-19 vaccines and their administration in accordance with §§1833(a)(1) and 1833(a)(10)(A) of the Social Security Act (the Act.)

The vaccine and administration of the pneumococcal and influenza virus, and COVID-19 vaccine is covered in §1861(s)(10)(A) of the Act; §1861(s)(10)(B) includes the hepatitis B vaccine and administration rather than under the physicians' services benefit. Therefore, it is not eligible for the 10 percent Health Professional Shortage Area (HPSA) incentive payment or the 5 percent Physician Scarcity Area (PSA) incentive payment.

No Legal Obligation to Pay

Nongovernmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. (See Pub. 100-02, Medicare Benefit Policy Manual, chapter 16.) Thus, for example, Medicare may not pay for influenza virus vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees. Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients. (See §1128(b)(6)(A) of the Act.) When an employer offers free vaccinations to its employees, it must also offer the free vaccination to an employee who is also a Medicare beneficiary. It does not have to offer free vaccinations to its non-Medicare employees.

Nongovernmental entities that do not charge patients who are unable to pay or reduce their charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided, may bill Medicare and expect payment.

Governmental entities (such as PHCs) may bill Medicare for pneumococcal, hepatitis B, influenza virus, and COVID-19 vaccines administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries. Government entities may NOT bill Medicare for vaccine products during a public health emergency when vaccines are provided at no charge to Medicare and non-Medicare beneficiaries.

10.3 - Simplified Roster Claims for Mass Immunizers

(Rev. 13091; Issued:02-21-25; Effective: 01-01-25; Implementation: 07-07-25)

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass pneumococcal and influenza vaccination programs offered by PHCs and other individuals and entities that give the vaccine to a group of beneficiaries, e.g. at PHCs, shopping malls, grocery stores, senior citizen homes, and health fairs. Effective December 11, 2020, roster billing is also available for billing COVID-19 vaccinations.
Effective January 1, 2025, roster billing is available for hepatitis B vaccinations.
If they agree to accept assignment for these claims, properly licensed individuals and entities conducting mass immunization programs may submit claims using a simplified claim's filing procedure known as roster billing to bill for influenza virus, hepatitis B, pneumococcal or COVID-19 vaccinations for multiple beneficiaries. They may not collect any payment from the beneficiary. Entities that submit claims on roster claims must accept assignment and may not collect any "donation" or other cost sharing of any kind from Medicare beneficiaries for pneumococcal, influenza virus, hepatitis B, or COVID-19 vaccinations. However, the entity may bill Medicare for

the amount, which is not subsidized from its own budget. For example, an entity that incurs a cost of $7.50 per vaccination and pays $2.50 of the cost from its budget may bill Medicare the $5.00 cost which is not paid out of its budget.

A. Provider Enrollment Criteria for Mass Immunizers

Those entities and individuals that desire to provide mass immunization services, but may not otherwise be able to qualify as a Medicare provider, may be eligible to enroll as a provider type "Mass Immunization Roster Biller." In addition, claims submitted by the provider type "Mass Immunization Roster Biller" are always reimbursed at the assigned payment rate.
These individuals and entities must enroll by completing the Provider/Supplier Enrollment Application, Form CMS-855. Individuals and entities that enroll as this provider type may not bill Medicare for any services other than pneumococcal, influenza virus, hepatitis B, and/or COVID-19 vaccines and their administration.

B. Payment Floor for Roster Claims

Roster claims are considered paper claims and are not paid as quickly as electronic media claims (EMC). If available, offer electronic billing software free or at-cost to PHCs and other properly licensed individuals and entities. MACs (Part B) must ensure that the software is as user friendly as possible for the pneumococcal, influenza virus, hepatitis B, and COVID-19 vaccination billing.

10.3.1 - Roster Claims Submitted to A/B MACs (B) for Mass Immunization Roster Claims Submitted to AB MACs (B) for Mass Immunization

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

If the PHC or other individual or entity qualifies to submit roster claims, it may use a preprinted Form CMS-1500 that contains standardized information about the entity and the benefit. See Pub. 100-04, Chapter 26, §10 for more information about the CMS-1500 claim form. Key information from the beneficiary roster list and the abbreviated claim form is used to process pneumococcal, influenza, and COVID-19 vaccination claims.

Separate CMS-1500 claim forms, along with separate roster bills, must be submitted for influenza virus, pneumococcal, and COVID-19 roster billing.

If other services are furnished to a beneficiary along with pneumococcal, influenza, or COVID-19 vaccines, individuals and entities must submit claims using normal billing procedures, e.g., submission of a separate claim for each beneficiary.

MACs (Part B) must create and count one claim per beneficiary from roster bills. They must split claims for each beneficiary if there are multiple beneficiaries included in a roster bill. Providers must show the unit cost for one service on the claim. The MACs (Part B) must replicate the claim for each beneficiary listed on the roster.

MACs (Part B) must provide Palmetto-Railroad Retirement Board (RRB) with local pricing files for pneumococcal, influenza, and COVID-19 vaccines and their administration. If PHCs or other individuals or entities inappropriately bill pneumococcal, influenza, or COVID-19 vaccinations using the roster billing method, MACs (Part B) shall return the claim as unprocessable with the appropriate rejection message. MACs (Part B) may not deny these claims.

Providers must retain roster bills with beneficiaries' signatures at their permanent location for a time period consistent with Medicare regulations.

A. Modified Form CMS-1500 for Cover Document

Entities submitting roster bills to MACs (Part B) must complete the following blocks on a single modified Form CMS-1500 claim form, which serves as the cover document for the roster for each facility where services are furnished. In order for MACs (Part B) to reimburse by correct payment locality, a separate Form CMS-1500 must be used for each different facility or physical location where services are furnished.

Item #	Instruction
Item 1:	An X in the Medicare block
Item 2:	(Patient's Name): "SEE ATTACHED ROSTER"
Item 11:	(Insured's Policy Group or FECA Number): "NONE"
Item 20:	(Outside Lab?): An "X" in the NO block
Item 21:	(Diagnosis or Nature of Illness): Line A: Choose appropriate diagnosis code from §10.2.1 ICD Ind. Block: Enter ICD-10-CM code. Enter the indicator as a single digit between the vertical dotted lines.
Item 24B:	(Place of Service (POS)): Line 1: "60" Line 2: "60" NOTE: POS Code “60" must be used for roster billing.
Item 24D:	(Procedures, Services or Supplies): Line 1: Vaccine code Line 2: Vaccine Administration code
Item 24E:	(Diagnosis Pointer): Lines 1 and 2: "A"
Item 24F:	($ Charges): The entity must enter the charge for each listed service. If the entity is not charging for the vaccine or its administration, it should enter 0.00 or "NC" (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC pneumococcal or influenza virus vaccine claims only if your system is able to accept them.
Item 27:	(Accept Assignment): An "X" in the YES block.
Item 29:	(Amount Paid): "$0.00"
Item 31:	(Signature of Physician or Supplier): The entity's representative must sign the modified Form CMS-1500.
Item 32:	Enter the name, address, and ZIP code of the location where the service was provided (including centralized billers).
Item32a:	Enter the NPI of the service facility.
Item 33:	(Physician's, Supplier's Billing Name): The entity must complete this item.
Item 33a:	Effective May 23, 2007, and later, enter the NPI of the billing provider or group.

B. Format of Roster Claims

Qualifying individuals and entities must attach to the CMS-1500 claim form, a roster bill which contains the claims information regarding the supplier of the service and individual beneficiaries. While qualifying entities must use the modified Form CMS-1500 claim form without deviation, MACs (Part B) must work with these entities to develop a mutually suitable roster bill that contains the minimum data necessary to satisfy claims processing requirements for these claims. MACs (Part B) must key information from the beneficiary roster bill and abbreviated Form CMS-1500 claim form to process pneumococcal, influenza virus, and COVID-19 vaccination claims.

The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;

  NOTE: Providers must include the individual date of service for each beneficiary's vaccination on the roster bill.

- Control number for MAC (Part B);
- Patient's Medicare beneficiary identifier number;
- Patient's name;
- Patient's address;
- Date of birth;
- Patient's sex; and
- Beneficiary's signature or stamped "signature on file".

NOTE: A stamped "signature on file" qualifies as an actual signature on a roster bill if the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, the provider is not required to obtain the patient signature on the roster, but instead has the option of reporting signature on file in lieu of obtaining the patient's actual signature.

The pneumococcal roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering the pneumococcal vaccination.

WARNING: Beneficiaries must be asked if they have received a pneumococcal vaccination.

- Rely on patients' memory to determine prior vaccination status.

MACs (Part B) shall use the data on the CMS-1500 claim form cover sheet and the roster bill to correct or add missing claims data and continue to process the claims for payment.

Contractors shall not return a claim as unprocessable if the following data fields on the CMS-1500 are not completed:

Item 1,

Item 2, or
Item 20.

The MAC (Part B) shall allow the roster claims to continue to process for payment. The MAC (Part B) shall complete the incomplete fields if the data is available on the attached roster bill.

The MAC (Part B) may fill in missing or incomplete information on the attached roster bill when the required data such as provider's name and NPI is missing but is included on the abbreviated CMS-1500 claim form. The MAC shall fill in the missing information and continue to process the claim for payment.

10.3.1.1 - Centralized Billing for Influenza Virus and Pneumococcal Vaccines to A/B MACs (B)

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The CMS currently authorizes providers to centrally bill for influenza, pneumococcal, and COVID-19 vaccination claims. That is to say, they bill all of the claims for those vaccinations to one MAC, rather than to each of the MACs that service the location where the services are rendered.

Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type "Mass Immunization Roster Biller," as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

The contractor assigned to process the claims for centralized billing will be chosen at the discretion of The Centers for Medicare & Medicaid Services (CMS) based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. Currently the specialty contractor for centralized billing is Novitas (JH).

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different MACs processing claims. Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the vaccinations are given and the MAC will verify this through the enrollment process.

As previously stated, centralized billers must send all claims for influenza, pneumococcal, and COVID-19 vaccinations to a single MAC for payment, regardless of the jurisdiction in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) Payment is made based on the payment locality where the service was provided. Centralized billing is only available for claims for the influenza, pneumococcal, and COVID-19 vaccines and their administration. The general coverage and coding rules still apply to these claims.

This section applies only to those individuals and entities that provide mass immunization services for influenza, pneumococcal, and COVID-19 virus vaccinations that have been authorized by CMS to centrally bill. All other providers, including those individuals and entities that provide mass immunization services that are not authorized to centrally bill, must continue to submit claims to their regular MAC (Part B) per the instructions in §10.3.1 of this chapter.

The claims processing instructions in this section apply only to claims submitted to the designated processing MAC. However, all MACs (Part B) must follow the instructions in §10.3.1.1.J, below, "Provider Education Instructions for All MACs (Part B)."

A. Request for Approval

Centralized Billing for Influenza, Pneumococcal and COVID-19 Virus Vaccinations

A. **Information for Providers Interested in Applying for Centralized Billing**

In order to qualify as a centralized biller**,** a provider must be operating in at least three payment localities for which there are three different MACs processing claims.

Individuals and corporations who wish to enroll as a CMS centralized biller must send their request in writing to Novitas, (the current specialty contractor) at the address at the end of this section.

Providers must include the following information in their application to become a centralized biller.

1. Providers must indicate that they agree to the following:

a) Centralized billers providing the vaccine and administration must be properly licensed in the States in which the vaccinations are given.

b) Centralized biller must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the influenza, pneumococcal and COVID-19 vaccinations, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza virus vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. This practice is unacceptable.

c) Centralized billers must understand that beginning December 11, 2021 the payment rate for the administration of the COVID-19 vaccine is $40 and $30 for the other preventive vaccinations. These payment amounts are geographically adjusted by locality. Therefore, the centralized biller must be willing to accept that payments received may vary based on the geographic locality where the service was performed.

d) Centralized billers must understand that the payment rates for the vaccines will be determined by the standard method used by Medicare for reimbursement of drugs and biologicals.

e) Centralized billers must agree to submit their claims in a CMS approved electronic media claims standard format. Paper claims will not be accepted.

f) In addition to the elements required by regular roster billing, centralized billers must complete the service facility location in order for the MAC to be able to pay correctly by geographic locality. Centralized billers should contact the processing contractor for specific information.

g) Centralized billers must obtain certain information for each beneficiary including name, Medicare Beneficiary Identifier, date of birth, sex, and signature. Novitas must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the correct MBI as Novitas will not be able to process incomplete or incorrect claims.

h) Centralized billers must obtain an address for each beneficiary so that a Medicare Summary Notice (MSN) can be sent to the beneficiary. Beneficiaries are sometimes confused when they receive an MSN from a MAC other than the MAC that normally processes their claims, which results in unnecessary beneficiary inquiries to the MAC. Therefore, centralized billers must notify every beneficiary receiving an influenza, pneumococcal or COVID-19 virus vaccination that the claim will be processed by Novitas. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.

i) Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. Novitas can provide this information.

j) Though centralized billers may already have a National Provider Identifier (NPI) number, for purposes of centralized billing, they must also enroll with Novitas. This can be done by completing the Form CMS-855 (Provider Enrollment Application) that can be obtained from Novitas.

k) If the request for centralized billing is approved, for influenza and pneumococcal, and COVID-19 vaccinations, that approval is ongoing. It is the responsibility of the approved centralized billers to contact Novitas to make updates to their provider enrollment data on file (i.e. clinic locations, name change, and change to ownership are a few examples) **.** Claims submitted without approval will be denied.

l) If a centralized biller is applying to provide COVID-19 vaccinations only, that approval will be ongoing. It is the responsibility of the approved centralized billers to contact Novitas to make updates to their provider enrollment data on file (i.e. clinic locations, name change, and change to ownership are a few examples). Claims submitted without approval will be denied.

2. Applicants for centralized billing should also include responses to the following:

    a. A list of the States in which vaccination clinics will be held;
    b. Contact information for a designated contact for the centralized billing program.

Applications for centralized billing must be sent to the specialty MAC for centralized billing at:

Novitas Solutions, Inc.
Provider Enrollment Services
Attention: Centralized Billing Program
P.O. Box 3095
Mechanicsburg, PA 17055-1813

All applicants must meet the criteria for centralized billing at the time they apply for approval. Failure to provide a response to each statement will result in the request not being processed. Novitas will reach out to the applicant to attempt to complete any missing data. Should they be unable to resolve the matter via outreach efforts, Novitas shall return the application with details explaining why the submission could not be processed.

B. **Review of Applications**

Novitas will review the information provided by applicants for completeness. Novitas will approve or deny the applicant's request for participation based on the information provided. Applicants who are approved shall continue to the next steps of enrollment through Novitas' provider enrollment department.

Novitas will send a letter of disapproval to applicants who are determined ineligible to participate in the Medicare centralized billing program. The letter will clearly explain why the request was denied.

Submitting a request for participation does not automatically provide approval to set up vaccination clinics, vaccinate beneficiaries, and bill Medicare for reimbursement. All new participants must complete the approval process, including submission of a CMS-855 Application for enrollment with Novitas and receive a final approval before they vaccinate Medicare beneficiaries and bill Medicare for reimbursement.

If a provider's request is approved for centralized billing for influenza, pneumococcal and COVID-19 vaccinations, the approval shall be ongoing. Approved providers will no longer be required to reapply on an annual basis. Centralized billers shall contact Novitas with any changes to their enrollment and/or that states in which they operate.

C. Enrollment

COVID-19 Mass Immunizer Centralized Biller Enrollment
For more information on enrolling as a COVID-19 mass immunizer centralized biller go to:
https://www.cms.gov/medicare/covid-19/enrollment-administering-covid-19-vaccine-shots

D. Electronic Submission of Claims on Roster Bills

All centralized billers must agree to submit their claims on roster bills in an electronic media claims format. The processing contractor must provide instructions on acceptable roster billing formats to the approved centralized billers. Paper claims will not be accepted.

E. Required Information on Roster Bills for Centralized Billing

In addition to the roster billing instructions found in §10.3.1 of this chapter, centralized billers must provide on the claim the ZIP code of where the service was rendered (to determine the payment locality for the claim), and the provider of service/supplier's billing name, address, ZIP code, and telephone number. In addition, the NPI of the billing provider or group must be appropriately reported.

F. Payment Rates and Mandatory Assignment

The payment rates for the administration of the vaccinations are based on the Medicare Physician Fee Schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments vary based on the geographic locality where the service was performed.

The HCPCS codes G0008 and G0009 for the administration of the vaccines are not paid on the MPFS. However, prior to March 1, 2003, they must be paid at the same rate as HCPCS code 90782, which is on the MPFS. The designated contractor must pay per the correct MPFS file for each calendar year based on the date of service of the claim. Beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 are to be reimbursed at the same rate as HCPCS code 90471.

Effective for claims with dates of service January 1, 2020 through December 31, 2021, the payment rates for G0008, G0009, and G0010, rather than being linked to the MPFS payment rate for 90471, they were to be paid at the same rate as they had been in 2019.
Beginning January 1, 2022, the national payment rate for HCPCS G0008, G0009, and G0010 is $30. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for HCPCS G0008, G0009, and G0010 are available of the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing

Beginning January 1, 2022 and through the end of the calendar year in which the PHE for COVID-19 ends, the national payment rate for the administration of COVID-19 vaccines is $40. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for the administration of COVID-19 vaccines are available of the CMS website: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies

Effective January 1 of the year following the year in which the PHE for COVID-19 ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines.

In order to pay claims correctly for centralized billers, the designated contractor must have the correct name and address, including ZIP code, of where the service was provided.

The following remittance advice and Medicare Summary Notice (MSN) messages apply:

> **Claim adjustment reason code 16**, "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code,
>
> **Remittance advice remark code MA114**, "Missing/incomplete/invalid information on where the services were furnished."
>
> **MSN 9.4** - "This item or service was denied because information required to make payment was incorrect."

The payment rates for the vaccines must be determined by the standard method used by Medicare for reimbursement of drugs and biologicals. (See chapter 17 for procedures for determining the payment rates for vaccines.)

Effective for claims with dates of service on or after February 1, 2001, §114, of the Benefits Improvement and Protection Act of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, all providers Medicare covered preventive must accept assignment for the vaccine. In addition, as a requirement for both centralized billing and roster billing, providers must agree to accept assignment for the administration of the vaccines as well. This means that they must agree to accept the amount that Medicare pays for the vaccine and the administration. Also, since there is no coinsurance or deductible for the influenza, pneumococcal, and COVID-19 vaccine benefits, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination.

G. Common Working File Information

To identify these claims and to enable central office data collection on the project, special processing number 39 has been assigned. The number should be entered on the HUBC claim record to CWF in the field titled Demonstration Number.

H. Provider Education Instructions for the Designated Processing Part B MAC

The designated Part B MAC must fully educate the centralized billers on the processes for centralized billing as well as for roster billing. General information on influenza, pneumococcal, and COVID-19 vaccine coverage and billing instructions is available on the CMS Web site for providers.

I. Provider Education Instructions for All MACs (Part B)

By XXXX of every year, all MACs (Part B) must publish in their bulletins and put on their Web sites the following notification to providers. Questions from interested providers should be forwarded to Novitas, the designated processing Part B MAC for the centralized billing workload at the address below. MACs (Part B) must enter the name of the assigned processing contractor where noted before sending.

NOTIFICATION TO PROVIDERS

Centralized billing is a process in which a provider, who provides mass immunization services for influenza virus and pneumococcal pneumonia virus (PPV) immunizations, can send all claims to a single contractor for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the influenza virus and pneumococcal vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in influenza and pneumococcal centralized billing must contact Novitas, to begin centrally billing for influenza and pneumococcal vaccines.

Applications to become a mass immunizer centralized biller for the COVID-19 vaccine is an ongoing enrollment. Individuals and entities can submit a request to become a centralized mass immunizer at any time. For more information on enrolling as a COVID-19 mass immunizer centralized biller go to: **https://www.cms.gov/medicare/covid-19/enrollment-administering-covid-19-vaccine-shots .**

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

CRITERIA FOR CENTRALIZED BILLING

- To qualify for centralized billing, an individual or entity providing mass vaccination services for influenza virus, pneumococcal, and COVID-19 vaccinations must provide these services in at least three payment localities for which there are at least three different contractors processing claims.

- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.

- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza virus vaccination and give the beneficiary a coupon for $10 to be used in the drugstore.

  NOTE: The practice of requiring a beneficiary to pay for the vaccination upfront and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per §1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment.

- The contractor assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned contractor for this year is [Fill in name of contractor.]

- The payment rates for the administration of the vaccinations are based on the Medicare physician fee schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.

- The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.

- Centralized billers must submit their claims on roster bills in an approved electronic format. **Paper claims will not be accepted.**

- Centralized billers must obtain certain information for each beneficiary including name, MBI number, date of birth, sex, and signature. [The designated Part B MAC] must be contacted prior to submitting claims for verification of billing requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare Health Insurance Claim Number) as the contractor will not be able to process incomplete or incorrect claims.

- Centralized billers must obtain an address for each beneficiary so that a Medicare Summary Notice (MSN) can be sent to the beneficiary by the Part B MAC. Beneficiaries are sometimes confused when they receive an MSN from a Part B MAC other than the MAC that normally processes their claims which results in unnecessary beneficiary inquiries. Therefore, centralized billers must provide every beneficiary receiving an influenza virus or pneumococcal vaccination with the name of the

processing Part B MAC. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.

- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. [The designated Part B MAC] can provide this information.

- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from [The designated Part B MAC]. This can be done by completing the Form CMS-855 (Provider Enrollment Application), which can be obtained from [The designated Part B MAC].

  NOTE: Influenza/Pneumococcal Mass Immunizer Centralized Billers **DO NOT** need to enroll separately as a COVID-19 Mass Immunizer Centralized Biller to administer COVID-19 vaccine shots.

- If an individual or entity's request for centralized billing of influenza, pneumococcal, and/or COVID-19 vaccines is approved, the approval is ongoing. Claims will not be processed for any influenza, pneumococcal, or COVID-19 centralized biller without approval from the designated Part B MAC.

- Each year the centralized biller must contact the designated Part B MAC to verify understanding of the coverage policy for the administration of the pneumococcal vaccine, and for a copy of the warning language that is required on the roster bill.

- The centralized biller is responsible for providing the beneficiary with a record of the pneumococcal vaccination.

- The information in items 1 through 8 below must be included with the individual or entity's annual request to participate in centralized billing:

  1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations;

  2. Estimates for the number of beneficiaries who will receive pneumococcal vaccinations;

  3. Estimates for the number of beneficiaries who will receive COVID-19 vaccinations (if applicable);

  4. The approximate dates for when the vaccinations will be given;

  5. A list of the states in which influenza, pneumococcal, and COVID-19 vaccination clinics will be held;

  6. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse);

7. Whether the nurses who will administer the influenza, and pneumococcal, and COVID-19 vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza, pneumococcal, and COVID-19 vaccinations;

8. Names and addresses of all entities operating under the corporation's application (not clinic locations);

9. Contact information for designated contact person for centralized billing program.

10.3.2 - Claims Submitted to MACs (Part A) for Mass Immunizations of Influenza, Pneumococcal, and/or COVID-19 Virus Vaccinations

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

To increase the number of beneficiaries who obtain needed preventive vaccinations, simplified roster billing procedures are also available to mass immunizers that bill MACs (Part A). The simplified roster claims filing procedure has been expanded from availability for influenza and pneumococcal virus vaccinations to also include COVID-19 virus vaccinations. A mass immunizer is defined as any entity that gives the influenza, pneumococcal, or COVID-19 virus vaccinations to a group of beneficiaries, e.g., at public health clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date are required. (See §10.3.2.2 for an exception to this requirement for inpatient hospitals.)

The simplified roster billing claims filing procedure applies to providers other than RHCs and FQHCs that conduct mass immunizations. Since independent and provider based RHCs and FQHCs do not submit individual Form CMS-1450s for the influenza virus vaccine, they do not utilize the simplified billing process. Instead, payment is made for the vaccine at the time of cost settlement.

The simplified roster billing process involves use of the provider billing form (Form CMS-1450) with preprinted standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed Form CMS-1450 that contains the variable claims information regarding the service provider and individual beneficiaries.

Qualifying individuals and entities must attach a roster, which contains the variable claims information regarding the supplier of the service and individual beneficiaries.

The roster must contain at a minimum the following information:

- Provider name and NPI;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;

- Patient Medicare Beneficiary Identifier (MBI) number; and
- Beneficiary signature or stamped "signature on file."

In addition, for inpatient Part B services (12x and 22X) the following data elements are also needed:

- Admission date;
- Admission type;
- Admission diagnosis;
- Admission source code; and
- Patient status code.

NOTE: A stamped "signature on file" can be used in place of the beneficiary's actual signature for all institutional providers that roster bill from an inpatient or outpatient department provided the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, they are not required to obtain the patient signature on the roster. However, the provider has the option of reporting "signature on file" in lieu of obtaining the patient's actual signature on the roster.

The pneumococcal vaccination roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering the pneumococcal vaccine.

Warning: Beneficiaries must be asked if they have been vaccinated with the pneumococcal vaccine.

- Rely on the patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine,
- If patients are certain that they have been vaccinated within the past 5 years, **do not revaccinate**.

For providers using the simplified billing procedure, the modified Form CMS-1450 shows the following preprinted information in the specific form locators (FLs). Information regarding the form locator numbers that correspond to the data element names below is found in Chapter 25:

- The words "See Attached Roster" (Patient Name);
- Patient Status code 01 (Patient Status);
- Condition code M1 (Condition Code) (See NOTE below);
- Condition code A6 (Condition Code);

- Revenue code 636 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- Revenue code 771 (Revenue Code), along with the appropriate "G" HCPCS code (HCPCS Code);
- "Medicare" (Payer, line A);
- The words "See Attached Roster" (Provider Number, line A); and
- Diagnosis code
    - **ICD-10-CM** - Use Z23 for an encounter for immunization effective with the implementation of ICD-10.
- Influenza virus and COVID-19 vaccines require:
    - the provider's own NPI to be reported in the NPI field for the attending physician on claims submitted on or after May 23, 2007.

Providers conducting mass immunizations are required to complete the following fields on the preprinted Form CMS-1450:

- Type of Bill;
- Total Charges;
- Provider Representative; and
- Date.

NOTE: Medicare Secondary Payer (MSP) utilization editing is bypassed in CWF for all mass immunization roster bills. However, if the provider knows that a particular group health plan covers the pneumococcal vaccine and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed. First claim development alerts from CWF are not generated for influenza, pneumococcal or COVID-19 vaccination claims.

Contractors use the beneficiary roster list to generate claim records to process the pneumococcal virus vaccination claims by mass immunizers indicating condition code M1 to avoid MSP editing. Standard System Maintainers must develop the necessary software to generate records that will process through their system.

Providers that do not mass immunize must continue to bill for the influenza, pneumococcal and COVID-19 virus vaccinations using the normal billing method, (e.g., submission of a Form CMS-1450 or electronic billing for each beneficiary).

10.3.2.1 - Simplified Billing for Influenza, Pneumococcal and COVID-19 Virus Vaccination Services by HHAs

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The following billing instructions apply to HHAs that roster bill for influenza virus and pneumococcal vaccines.

- When an HHA provides the influenza virus vaccine or the pneumococcal vaccine in a mass immunization setting, it does not have the option to pick and choose whom to bill for this service. If it is using employees from the certified portion, and as a result will be reflecting these costs on the cost report, it must bill the A/B MAC (HHH) on the Form CMS-1450.

- If the HHA is using employees from the noncertified portion of the agency (employees of another entity that are not certified as part of the HHA), and as a result, will not be reflecting these costs on the cost report, it must obtain a provider number and bill their A/B MAC (B) on the Form CMS-1500.

- If employees from both certified and noncertified portions of the HHA furnish the vaccines at a single mass immunization site, they must prepare two separate rosters, e.g., one for employees of the certified portion to be submitted to the A/B MAC (HHH) and one roster for employees of the noncertified portion to be submitted to the A/B MAC (B).

10.3.2.2 - Hospital Inpatient Roster Billing

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The following billing instructions apply to hospitals that roster bill for the influenza, pneumococcal and/or COVID-19 vaccinations provided to inpatients:

- Hospitals do not have to wait until patients are discharged to provide the vaccine. They may provide it anytime during the patient's stay;

- The roster should reflect the actual date of service;

- The requirement to provide the vaccine to five or more patients at the same time to meet the requirements for mass immunizers is waived when vaccines are provided to hospital inpatients. Therefore, the roster may contain fewer than five patients or fewer than five patients on the same day; and

    - The roster should contain information indicating that the vaccines were provided to inpatients to avoid questions regarding the number of patients or various dates.

10.3.2.3 - Electronic Roster Claims

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

As for all other Medicare-covered services, MACs (Part A) pay electronic claims more quickly than paper claims. For payment floor purposes, roster bills are paper bills and may not be paid as quickly as EMC. (See Chapter 1.) If available, MACs (Part A) must offer free, or at-cost,

electronic billing software and ensure that the software is as user friendly as possible to roster bill for the influenza, pneumococcal and COVID-19 vaccinations.

10.4.1 - CWF Edits on MAC (Part A) Claims
(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

In order to prevent duplicate payment by the same MAC (Part A), CWF edits by line item on the MAC (Part A) number, the Medicare Beneficiary Identifier (MBI) number, and the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658**,** 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688**,** 90694, or 90756 and the pneumococcal procedure codes 90670, 90671, 90677, or 90732, and the administration code, G0008 or G0009 .

1. If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with the same MBI number, same MAC (Part A) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF rejects.
2. If CWF receives a claim with HCPCS codes 90670, 90671, 90677, or 90732 and it already has on record a claim with the same MBI number, same MAC (Part A) number, same date of service, and the same HCPCS code, the second claim submitted to CWF rejects when all four items match.
3. If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same MBI number, same MAC (Part A) number, same date of service, and same procedure code, CWF rejects the second claim submitted when all four items match.

CWF returns to the MAC (Part A) a reject code “7262” for this edit. MACs (Part A) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

10.4.2 - CWF Edits on MAC (Part B) Claims
(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

In order to prevent duplicate payment by the same MAC (Part B), CWF will edit by line item on the MAC (Part B) number, the MBI number, the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal procedure codes 90670, 90671, 90677, or 90732; and the administration code G0008 or G0009.

1. If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656,90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with the same MBI number, same MAC (Part B) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF will reject.

2. If CWF receives a claim with HCPCS codes 90670, 90671, 90677, or 90732 and it already has on record a claim with the same MBI number, same MAC (Part B) number,

same date of service, and the same HCPCS code, the second claim submitted to CWF will reject when all four items match.

3. If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same MBI number, same MAC (Part B) number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return to the MAC (Part B) a specific reject code for these edits. MACs (Part B) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

In order to prevent duplicate payment by the centralized billing contractor and local MAC (Part B), CWF will edit by line item for MAC (Part B) number, same MBI number, same date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal virus procedure codes 90670, 90671, 90677, or 90732; and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with a different MAC (Part B) number, but same MBI number, same date of service, and any one of those same HCPCS codes, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS codes 90670, 90671, 90677, or 90732 and it already has on record a claim with the same MBI number, different MAC (Part B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with a different MAC (Part B) number, but the same MBI number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return a specific reject code for these edits. MACs (Part B) must deny the second claim. The reject code should automatically trigger the following Medicare Summary Notice (MSN) and Remittance Advice (RA) messages.

MSN: 7.2 – “This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.”

Claim Adjustment Reason Code 18 – Exact duplicate claim/service

EDITS FOR CLAIMS SUBMITTED TO THE CENTRALIZED BILLING PROCESSING MAC (PART B) AND THE LOCAL MAC (PART B)

In order to prevent duplicate payment by the centralized billing contractor and local MAC (Part B), CWF will edit by line item for MAC (Part B) number, same MBI number, same date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal virus procedure codes 90670, 90671, 90677, or 90732; and the administration code G0008 or G0009.

1) If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with a different MAC (Part B) number, but same MBI number, same date of service, and any one of those same HCPCS codes, the second claim submitted to CWF will reject.

2) If CWF receives a claim with HCPCS codes 90670, 90671, 90677, or 90732 and it already has on record a claim with the same MBI number, different MAC (Part B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject.

3) If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with a different MAC (Part B) number, but the same MBI number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return a specific reject code for these edits. MACs (Part B) must deny the second claim. The reject code should automatically trigger the following Medicare Summary Notice (MSN) and Remittance Advice (RA) messages.

MSN: 7.2 – "This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them."

Claim Adjustment Reason Code 18 – Exact duplicate claim/service

10.4.3 - CWF Crossover Edits for A/B MAC (B) Claims

(Rev. 11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

When CWF receives a claim from the MAC (Part B), it will review Part B outpatient claims history to verify that a duplicate claim has not already been posted.

CWF will edit on the beneficiary MBI number; the date of service; the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal procedure codes 90670,90671, 90677, or 90732; and the administration code G0008 or G0009.

CWF will return a specific reject code for this edit. MACs (B) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

20 - Mammography Services (Screening and Diagnostic)

(Rev. 1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

A. Screening Mammography

Beginning January 1, 1991, Medicare provides Part B coverage of screening mammographies for women. Screening mammographies are radiologic procedures for early detection of breast cancer and include a physician's interpretation of the results. A doctor's prescription or referral is not necessary for the procedure to be covered. Whether payment can be made is determined by a

woman's age and statutory frequency parameter. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.3 for additional coverage information for a screening mammography.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over age 39 and waives the Part B deductible. Coverage applies as follows:

Age Groups	Screening Period
Under age 35	No payment allowed for screening mammography.
35-39	Baseline (pay for only one screening mammography performed on a woman between her 35th and 40th birthday)
Over age 39	Annual (11 full months have elapsed following the month of last screening

NOTE: Count months between screening mammographies beginning the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination in January 2005, begin counting the next month (February 2005) until 11 months have elapsed. Payment can be made for another screening mammography in January 2006.

B. Diagnostic Mammography

A diagnostic mammography is a radiological mammogram and is a covered diagnostic test under the following conditions:

- A patient has distinct signs and symptoms for which a mammogram is indicated;
- A patient has a history of breast cancer; or
- A patient is asymptomatic, but based on the patient's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.
- Beginning January 1, 2005, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, §644, Public Law 108-173 has changed the way Medicare pays for diagnostic mammography. Medicare will pay based on the MPFS in lieu of OPPS or the lower of the actual change.

20.1 - Certification of Mammography Facilities

(Rev. 1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

The Mammography Quality Standards Act (MQSA) provides specific standards regarding those qualified to perform screening and diagnostic mammograms and how they should be certified. The MQSA requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards. Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the Food and Drug Administration (FDA) to continue to operate. The FDA, Center for Devices and

Radiological Health, is responsible for collecting certificate fees and surveying mammography facilities (screening and diagnostic).

The FDA provides CMS with a listing of all providers that have been issued certificates to perform mammography services and CMS notifies A/B MACs (A) and (B) accordingly. A/B MACs (A) and (B) are also notified of situations where a provider's certificate has expired, or has been suspended or revoked. The information provided includes the provider's name, address, 6-position certification number, effective/expiration dates and the letter "T" to designate the facility as terminated.

Medicare will reimburse only FDA-certified mammography centers for mammography services. A/B MACs (B) must inform physicians and suppliers at least annually, through their provider/supplier publications, of those facilities centers, that are certified. A/B MACs (B) encourage physicians to inform their patients about centers that are certified.

Mammography facilities that perform screening mammographies are **not** to release screening mammography x-rays for interpretation to physicians who are not approved under the facility's certification number unless the patient has requested a transfer of the mammography from one facility to another for a second opinion, or unless the patient has moved to another part of the country where the next screening mammography will be performed. Interpretations are to be performed **only** by physicians who are associated with the certified mammography facility. A/B MACs (B) are not required to maintain a list of these associations unless there is a specific reason for doing so and only on a case-by-case basis.

When adjudicating a screening mammography claim, MACs refer to the table of certified facilities provided by the FDA through CMS and confirm that the facility listed on the claim is in fact certified to perform the service. When the MAC determines that the facility that performed the mammography service has not been issued a certificate by the FDA or the certificate is suspended or revoked, the claim will be denied utilizing the denial language in §20.8.1 of this chapter, related to certified facilities.

20.1.1 - Services Under Arrangements

(Rev. 1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

When mammography services are obtained for patients under arrangements with another facility, the provider arranging the service must ensure that the facility performing the services has been issued an MQSA certificate by the FDA.

20.1.2 - FDA Certification Data

(Rev. 1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

The FDA furnishes data to CMS on a weekly basis, which specify the certification of facilities under the MQSA. This data are contained in a "MQSA file."

Prior to April 1, 2003, the MQSA file showed all facilities that are certified to perform film screening and diagnostic mammograms. After April 1, 2003, the file shows a new Record Type with two indicators, "1" for film and "2" for digital to determine which mammograms the facility is certified to perform.

Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000, entitled "Modernization of Screening Mammography Benefit," provided new payment methodologies for both diagnostic and screening mammograms that utilize digital technology. The new digital mammography codes have a higher payment rate. In order for Medicare to know whether the mammography facility is certified to perform digital mammography and, therefore, due a higher payment rate, CMS relies upon the FDA certification data contained in the MQSA file. The FDA sends an updated file via the CMS Mainframe Telecommunications System (CMSTS), formerly Network Data Mover, on a weekly basis.

Effective July 1, 2006, the MQSA file shows:

- Name of Facility,
- Certification number of the facility,
- Film certification obtained (Record-type =1) or digital certification obtained (Record-type = 2),
- Effective and Expiration dates of each certification,
- Letter "T" to designate the facility as terminated,

Some mammography facilities are certified to perform both film and digital mammography. In this case, the facility's name and FDA certification number shows up on this file twice. One line will indicate film certification with effective date/expiration date while the other line will indicate digital certification with effective date/expiration date.

NOTE: The FDA does not issue printed certification which indicates film or/and digital. Refer to the MQSA file for proof of types of mammography the facility is certified to perform.

If the MQSA file appears to be in error, contact your regional office mammography coordinator. The coordinators will contact the FDA to research the apparent error.

20.2 - HCPCS and Diagnosis Codes for Mammography Services

(Rev. 12435, Issued:12-28-23, Effective:01-29-24, Implementation:01-29-24)

The following HCPCS codes are used to bill for mammography services.

HCPCS Code	Definition
77065* (G0206*)	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral

HCPCS Code	Definition
77066* (G0204*)	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067* (G0202*)	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed
77063**	Screening Breast Tomosynthesis; bilateral (list separately in addition to code for primary procedure).
G0279**	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to code for primary procedure)

***NOTE:** For claims with dates of service January 1, 2017 through December 31, 2017 providers report HCPCS codes G0202, G0204, and G0206. For claims with dates of service on or after January 1, 2018 providers report CPT codes 77067, 77066, and 77065 respectively.

****NOTE:** HCPCS codes 77063 and G0279 are effective for claims with dates of service on or after January 1, 2015.

New Modifier "-GG": Performance and payment of a screening mammography and diagnostic mammography on same patient same day - This is billed with the Diagnostic Mammography code to show the test changed from a screening test to a diagnostic test. A/B MACs (A) and (B) will pay both the screening and diagnostic mammography tests. This modifier is for tracking purposes only. This applies to claims with dates of service on or after January 1, 2002.

A. Diagnosis for Services On or After Oct 1, 2015

The BBA of 1997 eliminated payment based on high-risk indicators. However, to ensure proper coding, one of the following diagnosis codes should be reported on screening mammography claims as appropriate:

ICD-10-CM

Z12.31 - Encounter for screening mammogram for malignant neoplasm of breast.

Beginning October 1, 2003, A/B MACs (B) are not permitted to plug the code for a screening mammography when the screening mammography claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.

In general, providers report diagnosis codes in accordance with the instructions in the appropriate ASC X12 837 claim technical report 3 (institutional or professional) and the paper claim form instructions found in chapters 25 (institutional) and 26 (professional).

In addition, for institutional claims, providers report diagnosis code Z12.31 (if ICD-10-CM is applicable) in "Principal Diagnosis Code" if the screening mammography is the only service reported on the claim. If the claim contains other services in addition to the screening mammography, these diagnostic code Z12.31 (ICD-10-CM) are reported, as appropriate, in "Other Diagnostic Codes." **NOTE:** Information regarding the form locator number that corresponds to the principal and other diagnosis codes is found in chapter 25.

A/B MACs (B) receive this diagnosis in field 21 and field 24E with the appropriate pointer code of Form CMS-1500 or in Loop 2300 of ASC- X12 837 professional claim format.

ICD-10-CM Codes for a diagnostic mammography:

ICD-10 CM code	Definitions
C43.52	Malignant melanoma of skin of breast
C43.59	Malignant melanoma of other part of trunk
C44.511	Basal cell carcinoma of skin of breast
C44.519	Basal cell carcinoma of skin of other part of trunk
C44.521	Squamous cell carcinoma of skin of breast
C44.529	Squamous cell carcinoma of skin of other part of trunk
C44.591	Other specified malignant neoplasm of skin of breast
C44.599	Other specified malignant neoplasm of skin of other part of trunk
C45.9	Mesothelioma, unspecified
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.021	Malignant neoplasm of nipple and areola, right male breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast

C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C77.3	Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.40	Secondary malignant neoplasm of unspecified part of nervous system
C79.49	Secondary malignant neoplasm of other parts of nervous system
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.61	Secondary malignant neoplasm of right ovary
C79.62	Secondary malignant neoplasm of left ovary
C79.81	Secondary malignant neoplasm of breast
C80.0	Disseminated malignant neoplasm, unspecified
C80.1	Malignant (primary) neoplasm, unspecified
C84.7A	Anaplastic large cell lymphoma, ALK-negative, breast
D03.52	Melanoma in situ of breast (skin) (soft tissue)
D03.59	Melanoma in situ of other part of trunk
D04.5	Carcinoma in situ of skin of trunk
D05.01	Lobular carcinoma in situ of right breast
D05.02	Lobular carcinoma in situ of left breast
D05.11	Intraductal carcinoma in situ of right breast
D05.12	Intraductal carcinoma in situ of left breast
D05.81	Other specified type of carcinoma in situ of right breast
D05.82	Other specified type of carcinoma in situ of left breast
D22.5	Melanocytic nevi of trunk
D23.5	Other benign neoplasm of skin of trunk
D24.1	Benign neoplasm of right breast

D24.2	Benign neoplasm of left breast
D48.5	Neoplasm of uncertain behavior of skin
D48.61	Neoplasm of uncertain behavior of right breast
D48.62	Neoplasm of uncertain behavior of left breast
D49.1	Neoplasm of unspecified behavior of respiratory system
D49.6	Neoplasm of unspecified behavior of brain
D49.7	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
I80.8	Phlebitis and thrombophlebitis of other sites
M70.80	Other soft tissue disorders related to use, overuse and pressure of unspecified site
M70.88	Other soft tissue disorders related to use, overuse and pressure other site
M70.89	Other soft tissue disorders related to use, overuse and pressure multiple sites
M79.5	Residual foreign body in soft tissue
M79.81	Nontraumatic hematoma of soft tissue
M79.89	Other specified soft tissue disorders
N60.01	Solitary cyst of right breast
N60.02	Solitary cyst of left breast
N60.11	Diffuse cystic mastopathy of right breast
N60.12	Diffuse cystic mastopathy of left breast
N60.21	Fibroadenosis of right breast
N60.22	Fibroadenosis of left breast
N60.31	Fibrosclerosis of right breast
N60.32	Fibrosclerosis of left breast
N60.41	Mammary duct ectasia of right breast
N60.42	Mammary duct ectasia of left breast
N60.81	Other benign mammary dysplasias of right breast
N60.82	Other benign mammary dysplasias of left breast
N61.0	Mastitis without abscess
N61.1	Abscess of the breast and nipple
N61.21	Granulomatous mastitis, right breast
N61.22	Granulomatous mastitis, left breast
N61.23	Granulomatous mastitis, bilateral breast
N62	Hypertrophy of breast
N63.11	Unspecified lump in right breast, upper outer quadrant
N63.12	Unspecified lump in right breast, upper inner quadrant
N63.13	Unspecified lump in right breast, lower outer quadrant
N63.14	Unspecified lump in right breast, lower inner quadrant
N63.15	Unspecified lump in right breast, overlapping quadrants
N63.21	Unspecified lump in the left breast, upper outer quadrant
N63.22	Unspecified lump in left breast, upper inner quadrant
N63.23	Unspecified lump in left breast, lower outer quadrant
N63.24	Unspecified lump in left breast, lower inner quadrant
N63.25	Unspecified lump in left breast, overlapping quadrants
N63.31	Unspecified lump in axillary tail of the right breast
N63.32	Unspecified lump in axillary tail of the left breast

N63.41	Unspecified lump in right breast, subareolar
N63.42	Unspecified lump in left breast, subareolar
N64.0	Fissure and fistula of nipple
N64.1	Fat necrosis of breast
N64.2	Atrophy of breast
N64.3	Galactorrhea not associated with childbirth
N64.4	Mastodynia
N64.51	Induration of breast
N64.52	Nipple discharge
N64.53	Retraction of nipple
N64.59	Other signs and symptoms in breast
N64.81	Ptosis of breast
N64.82	Hypoplasia of breast
N64.89	Other specified disorders of breast
N64.9	Disorder of breast, unspecified
N65.0	Deformity of reconstructed breast
N65.1	Disproportion of reconstructed breast
R59.0	Localized enlarged lymph nodes
R59.1	Generalized enlarged lymph nodes
R59.9	Enlarged lymph nodes, unspecified
R92.0	Mammographic microcalcification found on diagnostic imaging of breast
R92.1	Mammographic calcification found on diagnostic imaging of breast
R92.2	Inconclusive mammogram
R92.30	Dense breasts, unspecified
R92.311	Mammographic fatty tissue density, right breast
R92.312	Mammographic fatty tissue density, left breast
R92.313	Mammographic fatty tissue density, bilateral breasts
R92.321	Mammographic fibroglandular density, right breast
R92.322	Mammographic fibroglandular density, left breast
R92.323	Mammographic fibroglandular density, bilateral breasts
R92.331	Mammographic heterogeneous density, right breast
R92.332	Mammographic heterogeneous density, left breast
R92.333	Mammographic heterogeneous density, bilateral breasts
R92.341	Mammographic extreme density, right breast
R92.342	Mammographic extreme density, left breast
R92.343	Mammographic extreme density, bilateral breasts
R92.8	Other abnormal and inconclusive findings on diagnostic imaging of breast
R93.9	Diagnostic imaging inconclusive due to excess body fat of patient
S20.01xA	Contusion of right breast, initial encounter
S20.02xA	Contusion of left breast, initial encounter
S21.011A	Laceration without foreign body of right breast, initial encounter
S21.012A	Laceration without foreign body of left breast, initial encounter
S21.021A	Laceration with foreign body of right breast, initial encounter
S21.022A	Laceration with foreign body of left breast, initial encounter
S21.031A	Puncture wound without foreign body of right breast, initial encounter
S21.032A	Puncture wound without foreign body of left breast, initial encounter

S21.041A	Puncture wound with foreign body of right breast, initial encounter
S21.042A	Puncture wound with foreign body of left breast, initial encounter
S21.051A	Open bite of right breast, initial encounter
S21.052A	Open bite of left breast, initial encounter
S28.211A	Complete traumatic amputation of right breast, initial encounter
S28.212A	Complete traumatic amputation of left breast, initial encounter
S28.221A	Partial traumatic amputation of right breast, initial encounter
S28.222A	Partial traumatic amputation of left breast, initial encounter
S29.091A	Other injury of muscle and tendon of front wall of thorax, initial encounter
S29.099A	Other injury of muscle and tendon of unspecified wall of thorax, initial encounter
S29.8xxA	Other specified injuries of thorax, initial encounter
S39.091A	Other injury of muscle, fascia and tendon of abdomen, initial encounter
S39.81xA	Other specified injuries of abdomen, initial encounter
T85.41xA	Breakdown (mechanical) of breast prosthesis and implant, initial encounter
T85.42xA	Displacement of breast prosthesis and implant, initial encounter
T85.43xA	Leakage of breast prosthesis and implant, initial encounter
T85.44xA	Capsular contracture of breast implant, initial encounter
T85.49xA	Other mechanical complication of breast prosthesis and implant, initial encounter
T85.79xA	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z77.123	Contact with and (suspected) exposure to radon and other naturally occurring radiation
Z77.128	Contact with and (suspected) exposure to other hazards in the physical environment
Z77.9	Other contact with and (suspected) exposures hazardous to health
Z85.3	Personal history of malignant neoplasm of breast
Z85.831	Personal history of malignant neoplasm of soft tissue
Z85.89	Personal history of malignant neoplasm of other organs and systems
Z86.000	Personal history of in-situ neoplasm of breast
Z91.89	Other specified personal risk factors, not elsewhere classified
Z92.89	Personal history of other medical treatment
Z98.82	Breast implant status
Z98.86	Personal history of breast implant removal

20.2.1 - Digital Breast Tomosynthesis

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

A. Screening Breast Tomosynthesis

Effective for claims with dates of service January 1, 2017 through December 31, 2017, HCPCS code 77063, “Screening Digital Breast Tomosynthesis, bilateral, must be billed in conjunction with

the primary service mammogram code G0202. Effective for claims with dates of service January 1, 2018 and later HCPCS code 77063, "Screening Digital Breast Tomosynthesis, bilateral, must be billed in conjunction with the primary service mammogram code 77067.

A/B MACs (A) and (B) must assure that claims containing code 77063 also contain HCPCS code 77067* (G0202*). A/B MACs (A) return claims containing code 77063 that do not also contain HCPCS code 77067* (G0202*)with an explanation that payment for code 77063 cannot be made when billed alone. A/B MACs (B) deny payment for 77063 when billed without 77067* (G0202*).

NOTE: When screening digital breast tomosynthesis, code 77063, is billed in conjunction with a screening mammography, code 77067* (G0202*), and the screening mammography 77067* (G0202*) fails the age and frequency edits in CWF, both services will be rejected by CWF.

B. Diagnostic Breast Tomosynthesis

Effective with claims with dates of service January 1, 2017 through December 31, 2017 HCPCS code G0279, "Diagnostic digital breast tomosynthesis, unilateral or bilateral", must be billed in conjunction with the primary service mammogram code G0204 or G0206. Effective with claims with dates of service January 1, 2018 and later, HCPCS code G0279, "Diagnostic digital breast tomosynthesis, unilateral or bilateral", must be billed in conjunction with the primary service mammogram code 77065 or 77066.Effective for claims with dates of service January 1, 2017 through December 31, 2017 A/B MACs (A) and (B) must assure that claims containing code G0279 also contain HCPCS code G0204 or G0206. A/B MACs (A) or (B) deny claims containing code G0279 that do not also contain HCPCS code G0202 or G0206 with an explanation that payment for code G0279 cannot be made when billed alone. Effective for claims with dates of service January 1, 2018 and later A/B MACs (A) and (B) must assure that claims containing code G0279 also contain HCPCS code 77065 or 77066. A/B MACs (A) or (B) deny claims containing code G0279 that do not also contain HCPCS code 77065 or 77066 with an explanation that payment for code G0279 cannot be made when billed alone.

Claims for diagnostic breast tomosynthesis, HCPCS code G0279, submitted with a revenue code other than 0401, 096X, 097X, or 098X will be return to providers.

Claims for diagnostic breast tomosynthesis, HCPCS code G0279, submitted with a TOB other than 12X, 13X, 22X, 23X, or 85X will be return to providers.

20.2.2 - Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

When denying claim lines for HCPCS code 77063 that are not submitted with the diagnosis code V76.11 or V76.12, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

CARC: 167
RARC: N386

MSN: 14.9

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

When denying claim lines for HCPCS code G0279 that are not submitted with HCPCS 77066 or 77065

20.3 - Payment

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

There is no Part B deductible or coinsurance for screening mammographies. The anti-markup payment limitation on physician billing for diagnostic tests does not apply to these services. Following are three categories of billing for mammography services:

- Professional component of mammography services (that is the physician's interpretation of the results of the examination);
- Technical component (all other services); or
- Both professional and technical components (global). However, global billing is not permitted for services furnished in provider outpatient departments, except for CAHs electing the optional method of payment for mammography services furnished on or after January 1, 2002.

20.3.1 - Payment for Screening Mammography Services Provided On and After January 1, 2002

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

The payment limitation methodology does not apply to claims with dates of service on or after January 1, 2002.

A/B MAC (A) Claims

For claims with dates of service on or after January 1, 2002, §104 of the Benefits Improvement and Protection Act (BIPA) 2000, provides for payment of screening mammography under the Medicare physician fee schedule (MPFS) when furnished in hospitals, skilled nursing facilities (SNFs), and CAHs not electing the optional method of payment for outpatient services. However, payment under the physician fee schedule is not applicable to hospitals subject to the Outpatient Prospective Payment System (OPPS) until April 1, 2002.

The payment for code 77067* is equal to the lower of:

- The actual charge or
- Locality specific technical component payment amount under the MPFS.

Part B deductible and coinsurance does not apply. This is a final payment.

A/B MACs (A) use the benefit-pricing file provided by CMS to pay mammography codes.

Payment for the add-on code 76085 is made under the Medicare Physician Fee Schedule. Deductible does not apply, however, coinsurance is applicable.

*****For claims with dates of service prior to January 1, 2007, providers report CPT code 76092. For claims with dates of service January 1, 2007 and later, providers report CPT code 77057.

A/B MACs (B) Claims

Physicians and suppliers are paid by the A/B MACs (B) for all mammography tests (including screening mammography) under the MPFS. Separate prices for the technical component, the professional component and the global service are included on the MPFS.

The Medicare allowed charge is the lower of:

- The actual charge, or
- The MPFS amount for the service billed.

The Medicare payment for the service is 80 percent of the allowed charge. Coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Part B deductible is waived and does not apply to screening mammography.

As with other MPFS services, the nonparticipating provider reduction and the limiting charge provisions apply to all mammography tests (including screening mammography).

20.3.1.1 - Outpatient Hospital Mammography Payment Table

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Payment for screening mammography in the Hospital Outpatient Setting (Revenue code 403) is the lesser of charge, or TC of MPFS for code 77067* (G0202*). Neither deductible nor a coinsurance applies.

Payment for diagnostic mammography, bilateral in the Hospital Outpatient Setting (Revenue code 401) is the lesser of charge, or TC of MPFS for code 77066* (G0204*).

Payment for diagnostic mammography, unilateral in the Hospital Outpatient Setting (Revenue code 401) is the lesser of charge, or TC of MPFS for code 77065* (G0206*). Deductible and coinsurance apply.

Beginning January 1, 2005, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, §644, Public Law 108-173 has changed the way Medicare pays for diagnostic mammography. Medicare payment will be based on the MPFS. Payment will no longer be made under the OPPS.

20.3.1.2 - Critical Access Hospital Payment

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Payment to a CAH for screening mammography is not subject to applicable Part B deductible, but coinsurance does apply. Any deductible or coinsurance collected is deducted from the payment.

A. Under the Optional (All Inclusive) Method

Section 403(d) of the BBRA amended §1834(g) of the Act to permit a CAH to elect an optional method of payment for outpatient services. This option is effective for cost reporting periods beginning on or after October 1, 2001. A CAH may elect to be paid for outpatient services by reasonable costs for facility services and §202 of BIPA allows an amount equal to 115 percent of the allowed amount for professional component. (Costs related to professional services are excluded from the cost payment.)

CAHs electing the optional method of reimbursement bill the A/B MAC (A) with type of bill 85X, revenue code 0403 and HCPCS code 77067* (G0202*). They also include the professional component on a separate line, with revenue code 96X, 97X, or 98X and HCPCS code 77067* (G0202*).

B. Under the Standard Method

CAHs reimbursed on the standard method of payment bill the technical component of a screening mammography to the A/B MAC (A) on type of bill 85X, revenue code 0403 and HCPCS code 77067* (G0202*).

Professional services are billed to the A/B MAC (B) and paid based on the fee schedule by the A/B MAC (B).

For claims with dates of service on or after January 1, 2002, §104 of the Benefits Improvement and Protection Act (BIPA) 2000, provides for payment of screening mammographies under the Medicare physician fee schedule (MPFS) in CAHs not electing the optional method of payment for outpatient services.

20.3.1.2.1 - CAH Screening Mammography Payment Table

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Payment for Screening Mammography in the Critical Access Hospital Outpatient Setting

Method 1 (Standard)

	TOB	Rev Code	HCPCS	Payment
Services on or after January 1 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	77067* (G0202)*	A/B MAC (A) payment is 80% of the lower of the charge or the fee schedule amount.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.			77067* (G0202)*	A/B MACs (B) payment is 80% of the lower of the charge or MPFS amount for the technical component. The new A3 states payment for 76092 is lower of charge or locality specific TECHNICAL component amount under MPFS.

Method 2 (Optional Method) - Option available with cost reporting periods starting on or after October 1, 2001 and dates of service on or after July 1, 2001.

	TOB	Rev Code	HCPCS	Payment
Services on or after January 1 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	77067* (G0202)*	A/B MAC (A) payment is 80% of the lower of the charge or the fee schedule amount.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.	85X	96X, 97X, or 98X	77067* (G0202*)	A/B MAC (A) pays 115% of 80% (that is 92%) of the lower of the charge or the MPFS amount.

20.3.1.3 - SNF Mammography Payment

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Payment for screening mammography in a SNF is equal to the lower of:

charge, or TC of MPFS for code 77067. No deductible, coinsurance applies.

Payment for diagnostic mammography, bilateral in a SNF is equal to the lower of: charge, or TC of MPFS for code 77066* (G0204*). Deductible and coinsurance apply. Payment for diagnostic mammography, unilateral in a SNF is equal to the lower of: charge, or TC of MPFS for code 77065* (G0206*). Deductible and coinsurance apply.

20.3.1.4 - Independent Diagnostic Testing Facility (IDTF) Mammography Payment

(Rev. 4071, Issued: 06-08-18, Issued: 07-09-18, Implementation: 07-09-18)

If an IDTF furnishes any type of mammography service (Screening or diagnostic), it must have a Food and Drug Administration (FDA) certification to perform such services. An entity that only performs diagnostic mammography service should not be enrolled as an IDTF.

Screening mammographies (including those that are self-referred) are payable by Medicare when performed in and by an IDTF entity.

For additional information, refer to 100-04 – Medicare Claims Processing Manual, Chapter 35 – Independent Diagnostic Testing Facility, Section 10.2 – Claims Processing.

20.4 - Billing Requirements - A/B MAC (A) Claims

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

A/B MACs use the weekly-updated MQSA file to verify that the billing facility is certified by the FDA to perform mammography services, and has the appropriate certification to perform the type of mammogram billed (film and/or digital). (See §20.1.) A/B MACs (A) use the provider number submitted on the claim to identify the facility and use the MQSA data file to verify the facility's certification(s). A/B MAC (A) complete the following activities in processing mammography claims:

- If the provider number on the claim does not correspond with a certified mammography facility on the MQSA file, then A/B MACs (A) deny the claim.

- When a film mammography HCPCS code is on a claim, the claim is checked for a "1" film indicator.

- If a film mammography HCPCS code comes in on a claim and the facility is certified for film mammography, the claim is paid if all other relevant Medicare criteria are met.

- If a film mammography HCPCS code is on a claim and the facility is certified for digital mammography only, the claim is denied.

- When a digital mammography HCPCS code is on a claim, the claim is checked for "2" digital indicator.

- If a digital mammography HCPCS code is on a claim and the facility is certified for digital mammography, the claim is paid if all other relevant Medicare criteria are met.

- If a digital mammography HCPCS code is on a claim and the facility is certified for film mammography only, the claim is denied.

NOTE: The Common Working File (CWF) no longer receives the mammography file for editing purposes.

Except as provided in the following sections for RHCs and FQHCs, the following procedures apply to billing for screening mammographies:

The technical component portion of the screening mammography is billed on Form CMS-1450 under bill type 12X, 13X, 14X**, 22X, 23X or 85X using revenue code 0403 and HCPCS code 77067* (G0202*).

The technical component portion of the diagnostic mammography is billed on Form CMS-1450 under bill type 12X, 13X, 14X**, 22X, 23X or 85X using revenue code 0401 and HCPCS code 77065* (G0206*),* 77066*(G0204).

Separate bills are required for claims for screening mammographies with dates of service prior to January 1, 2002. Providers include on the bill only charges for the screening mammography. Separate bills are not required for claims for screening mammographies with dates of service on or after January 1, 2002.

See separate instructions below for rural health clinics (RHCs) and federally qualified health centers (FQHCs).

* For claims with dates of service January 1, 2017 through December 31, 2017, providers report CPT codes G0202, G0204, and G0206. For claims with dates of service January 1, 2018 and later, providers report CPT codes 77067, 77066, and 77065 respectively.

** For claims with dates of service April 1, 2005 and later, hospitals bill for all mammography services under the 13X type of bill or for dates of service April 1, 2007 and later, 12X or 13X as appropriate. The 14X type of bill is no longer applicable. Appropriate bill types for providers other than hospitals are 22X, 23X, and 85X.

In cases where screening mammography services are self-referred and as a result an attending physician NPI is not available, the provider shall duplicate their facility NPI in the attending physician identifier field on the claim.

20.4.1 - Rural Health Clinics and Federally Qualified Health Centers (Rev. 4225, Issues: 02-01-19, Effective: 07-01-19, Implementation: 07-01-19)

A. Provider-Based RHC & FQHC - Technical Component
The technical component of a screening or diagnostic mammography is outside the scope of the RHC/FQHC benefit. In a provider-based RHC or FQHC, the technical component is billed by the base provider to the A/B MAC (A) under bill type 12X, 13X, 22X, 23X or 85X as appropriate using the base provider's outpatient provider number (not the RHC/FQHC provider number). The revenue code for a screening mammography is 0403, and the HCPCS code is 77067*, (G0202)*). The revenue code for a diagnostic mammography is 0401, and the HCPCS codes are 77065* (G0206*), 77066* (G0204*). Payment is based on the payment method for the base provider.

**G0236 is a deleted code after December 31, 2003. Use 76082* for claims with dates of service January 1, 2004 through December 31, 2006, and code 77051 for claims with dates of service January 1, 2007 and later.
* For claims with dates of service January 1, 2017 through December 31, 2017, report CPT codes G0206, G0204, and G0202. For claims with dates of service January 1, 2018 and later, report CPT codes 77065, 77066, and 77067respectively.

B. Independent RHCs and Freestanding FQHCs - Technical Component
The technical component of a screening or diagnostic mammography is outside the scope of the RHC/FQHC benefit. The practitioner that renders the technical service bills their A/B MACs (B) using Form CMS-1500. Payment is based on the MPFS national non- facility rate.

C. Provider-Based RHC & FQHC, Independent RHCs and Freestanding FQHCs - Professional Component
The professional component of a screening or diagnostic mammography is within the scope of the RHC/FQHC benefit and is billed under the RHC AIR or the FQHC PPS payment methodology with revenue code 052X. A/B MACs (A) should assure payment is not made for revenue code 0403 (screening mammography) or 0401 (diagnostic mammography). No payment is made on the line item reporting revenue code 0403.

For claims with dates of service on or after April 1, 2005, RHCs and FQHCs bill the A/B MAC (A) under bill type 71X or 77X for the professional component of a diagnostic mammography. No payment is made for the professional component of a diagnostic mammography unless there is a qualifying visit on the same day. The services should be billed with the appropriate revenue code. HCPCS coding is required for the diagnostic mammography.

20.4.2 - A/B MAC (A) Requirements for Nondigital Screening Mammographies

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

The A/B MAC (A) will consider the following when determining whether payment may be made:

- Presence of revenue code 0403;
- Presence of HCPCS code 77067* (G0206*);
- Presence of high risk diagnosis code indicator where appropriate;
- Date of last screening mammography; and
- Age of beneficiary.

The A/B MACs (A) must accept revenue code 0403 for bill types 13X, 22X, 23X, 71X, 73X, or 85X.

* For claims with dates of service January 1, 2017 thru December 31, 2017 providers report HCPCS code G0206. For claims with dates of service January 1, 2018 and later, providers report CPT code 77067.

20.4.2.1 - A/B MAC (A) Data for CWF and the Provider Statistical and Reimbursement Report (PS&R)

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

The CWF records are annotated with the date of the first (technical) screening mammography claim received. The record is updated based on the next covered (technical) claim received. A/B MACs (A) and (B) assume the claim is the first received for the beneficiary where records do not contain a date of last screening and process accordingly.

The A/B MACs (A) include revenue code, HCPCS code, units, and covered charges in the CWF record fields with the same name. They report the payment amount for revenue code 0403 in the CWF field named "Rate" and the billed charges in the field named "Charges" of the CWF record. In addition, A/B MACs (A) report special override code 1 in the field named "Special Action" of the CWF record to avoid application of the Part B deductible.

The A/B MACs (A) include in the financial data portion of the PS&R record, revenue code, HCPCS code, units, charges, and rate (fee schedule amount).

The PS&R system will include screening mammographies on a separate report from cost-based payments. See the PS&R guidelines for specific information.

20.5 - Billing Requirements - A/B MAC (B) Claims

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

A/B MACs (B) use the weekly-updated file to verify that the billing facility is certified by the FDA to perform mammography services, and has the appropriate certification to perform the type of mammogram billed (film and/or digital). A/B MACs (B) match the FDA assigned, 6-digit mammography certification number on the claim to the FDA mammography certification number

appearing on the file for the billing facility. A/B MACs (B) complete the following activities in processing mammography claims:

- If the claim does not contain the facility's 6-digit certification number, then A/B MACs (B) return the claim as unprocessable.

- If the claim contains a 6-digit certification number that is reported in the proper field or segment (as specified in the previous bullet) but such number does not correspond to the number specified in the MQSA file for the facility, then A/B MACs (B) deny the claim.

- When a film mammography HCPCS code is on a claim, the claim is checked for a "1" film indicator.

- If a film mammography HCPCS code comes in on a claim and the facility is certified for film mammography, the claim is paid if all other relevant Medicare criteria are met.

- If a film mammography HCPCS code is on a claim and the facility is certified for digital mammography only, the claim is denied.

- When a digital mammography HCPCS code is on a claim, the claim is checked for "2" digital indicator.

- If a digital mammography HCPCS code is on a claim and the facility is certified for digital mammography, the claim is paid if all other relevant Medicare criteria are met.

- Process the claim to the point of payment based on the information provided on the claim and in A/B MAC (B) claims history.

- Identify the claim as a screening mammography claim by the CPT-4 code and diagnosis code(s) listed on the claim.

- Assign physician specialty code 45 to facilities that are certified to perform only screening mammography.

- Ensure that entities that bill globally for screening mammography contain a blank in modifier position #1.

- Ensure that entities that bill for the technical component use only HCPCS modifier "-TC."

- Ensure that physicians who bill the professional component separately use HCPCS modifier "-26."

- Ensure all those who are qualified include the 6-digit FDA-assigned certification number of the screening center on the claim. Providers report this number in item 32 on the paper 1500 claim form. A/B MACs (B) retain this number in their provider files.

- When a mammography claim contains services subject to the anti-markup payment limitation and the service was acquired from another billing jurisdiction, the provider must submit their own NPI with the name, address, and ZIP code of the performing physician/supplier.

- Refer to Pub. 100-04, chapter 1, section 10.1.1.1., for claims processing instructions for payment jurisdiction.

- Beginning October 1, 2003, A/B MACs (B) are no longer permitted to add the diagnosis code for a screening mammography when the screening mammography claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.

A/B MAC (B) Provider Education

- Educate providers that when a screening mammography turns to a diagnostic mammography on the same day for the same beneficiary, add the "-GG" modifier to the diagnostic code and bill both codes on the same claim. Both services are reimbursable by Medicare.

- Educate providers that they cannot bill an add-on code without also billing for the appropriate mammography code. If just the add-on code is billed, the service will be denied. Both the add-on code and the appropriate mammography code should be on the same claim.

- Educate providers to submit their own NPI in place of an attending/referring physician NPI in cases where screening mammography services are self-referred.

20.5.1 - A/B MACs (B) Claim Record for CWF

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

B3-4601.3.B

A/B MACs (B) complete the type of service field in the CWF Part B claim record with a "B" if the patient is a high risk screening mammography patient or a "C" if she is a low risk screening mammography patient for services prior to January 1, 1998.

For services on or after January 1, 1998, the type of service field on CWF must have a value of "1" for medical care (screening) or a "4" for diagnostic radiology (diagnostic). Fill in POS. Fill in deductible indicator field with a "1"; not subject to deductible if screening mammography. Submit the claim to the CWF host. Trailer 17 of the Part B Basic Reply record will give the date of the last screening mammography.

The CWF edits for age and frequency for screening mammography. There are no frequency limitations on diagnostic tests.

20.5.2 - Transportation Costs for Mobile Units

(Rev. 1, 10-01-03)

B3-4601.2.J

Transportation costs are associated with mobile units for diagnostic mammography tests only. CMS formally added diagnostic mammography to the regulation language of the portable x-ray

benefit in 42 CFR 410.32(c)(3). These units are usually reserved for screening tests only. For the screening tests performed in a mobile unit, there is no separate transportation cost allowed. A/B MACs (B) should investigate transportation costs associated with the mobile mammography diagnostic tests that exceed data analysis guidelines.

To receive transportation payments, the approved portable x-ray supplier must also meet the certification requirements of §354 of the Public Health Service Act.

20.6 - Instructions When an Interpretation Results in Additional Films

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

A radiologist who interprets a screening mammography is allowed to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. When a radiologist's interpretation results in additional films, Medicare will pay for both the screening and diagnostic mammogram.

A/B MACs (B) Claims

For A/B MACs (B) claims, providers submitting a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach modifier "-GG" to the diagnostic mammography. A modifier "-GG" is appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Medicare will reimburse both the screening mammography and the diagnostic mammography.

A/B MAC (A) Claims

A/B MACs (A) require the diagnostic claim be prepared reflecting the diagnostic revenue code (0401) along with HCPCS code 77065*(G0206*), 77066*(G0204*), or G0279 and modifier "-GG" "Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day." Reporting of this modifier is needed for data collection purposes. Regular billing instructions remain in place for a screening mammography that does not fit this situation.

Both A/B MACs (A) and (B) systems must accept the GH and GG modifiers where appropriate.

* For claims with dates of service prior to January 1, 2017 thru December 31, 2017, providers report CPT codes G0206 and G0204. For claims with dates of service January 1, 2018 and later, providers report CPT codes 77065 and 77066 respectively.

20.7 - Mammograms Performed With New Technologies

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Section 104 of the Benefits Improvement and Protection Act 2000, (BIPA) entitled Modernization of Screening Mammography Benefit, provides for new payment methodologies for both diagnostic and screening mammograms that utilize advanced new technologies for the period April 1, 2001, to December 31, 2001 (to March 31, 2002 for hospitals subject to OPPS). Under this provision, payment for technologies that directly take digital images would equal 150 percent of the amount that would otherwise be paid for a bilateral diagnostic mammography. For technologies that convert standard film images to digital form, payment will be derived from the statutory screening mammography limit plus an additional payment of $15.00 for A/B MACs (B) claims and $10.20 for A/B MAC (A) (technical component only) claims.

Payment restrictions for digital screening and diagnostic mammography apply to those facilities that meet all FDA certifications as provided under the Mammography Quality Standards Act. However, CAD codes billed in conjunction with digital mammographies or film mammographies are not subject to FDA certification requirements.

Payment Requirements for Claims with Dates of Service on or After January 1, 2002 (April 1, 2002 for hospitals subject to OPPS).

A/B MAC (A) Payment

Code	Payment
77067* (G0202*)	Payment will be equal to the lower of the actual charge or the locality specific technical component payment amount under the MPFS when performed in a hospital outpatient department, CAH, or SNF. Deductible and coinsurance do not apply.
77066* (G0204*)	Payment will be made under OPPS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF and coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Deductible applies. **NOTE:** Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPPS.
77065* (G0206*)	Payment will be made under OPPS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF. Coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Deductible applies. **NOTE:** Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPPS.

Institutional providers bill for the technical portion of screening and diagnostic mammograms on Form CMS-1450 (or electronic equivalent) under bill type 13X, 22X, 23X, or 85X.

Institutional providers bill for digital screening mammographies on Form CMS-1450, utilizing revenue code 0403 and HCPCS G0202 or G0203.

Institutional providers bill for digital diagnostic mammographies on Form CMS-1450, utilizing revenue code 0401 and HCPCS G0204, G0205, G0206 or G0207.

NOTE: Codes G0203, G0205 and G0207 are not billable codes for claims with dates of service on or after January 1, 2002.

CAHs electing the optional method of payment for outpatient services are paid according to §20.3.2.3 of this chapter.

A/B MACs (B) Payment

All codes paid by the A/B MACs (B) are based on the Medicare Physician Fee Schedule (MPFS).

Code	Payment
77067* (G0202*)	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file. Part B deductible does not apply, however, coinsurance applies.
77066* (G0204*)	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file. Deductible and coinsurance apply.
77065* (G0206*)	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file. Deductible and coinsurance apply.

The professional component is billed to the A/B MACs (B) on Form CMS-1500 (or electronic equivalent).

A/B MACs (A) and (B) were furnished a mammography benefit pricing file to pay claims containing the above codes.

20.8 - Beneficiary and Provider Notices
(Rev. 1, 10-01-03)

B3-4601.4, A3-3660.10.I, SNF-537.2.G

20.8.1 - MSN Messages
(Rev. 3961, Issued: 02-02- 18, Effective: 01-01- 18, Implementation: 07-02-18)

B3-4601.4, A3-3660.10.I

The following messages are used on the MSN.

If the claim is denied because the beneficiary is under 35 years of age, use the following MSN:

MSN 18.3:

Screening mammography is not covered for women under 35 years of age.

The Spanish version of this MSN message should read:

Las pruebas de mamografía para mujeres menores de 35 años no están cubiertas.

If the claim is denied for a woman 35-39 because she has previously received this examination, use the following MSN:

MSN 18.6:

A screening mammography is covered only once for women age 35-39.

The Spanish version of this MSN message should read:

Una mamografía de cernimiento es cubierta una vez solamente para mujeres entre las edades de 35-39.

If the claim is denied because the period of time between screenings for the woman based on age has not passed, use the following MSN:

MSN 18.4:

This service is being denied because it has not been 12 months since your last examination of this kind. (NOTE: Insert appropriate number of months.)

The Spanish version of this MSN message should read:

Este servicio se denegó debido a que no han transcurrido 12 meses desde su último examen de este tipo.

If the claim is denied because the provider is not certified to perform a mammography, use the following MSN:

MSN 16.2:

This service cannot be paid when provided in this location/facility.

The Spanish version of this MSN message should read:

Este servicio no se puede pagar cuando es suministrado en este sitio/facilidad.

In addition to the above denial messages, the A/B MAC (A) or (B) may add the following:

MSN 18.12:

Screening mammograms are covered annually for women 40 years of age and older.

The Spanish version of this MSN message should read:

El examen de mamografía de cernimiento se cubre una vez al año para mujeres de 40 años de edad o más.

For A/B MACs (B) only:

For claims submitted with invalid or missing certification number, use the following MSN:

MSN 9.2:

This item or service was denied because information required to make payment was missing.

The Spanish version of this MSN message should read:

Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida.

20.8.2 - Remittance Advice Messages

(Rev. 3961, Issued: 02-02- 18, Effective: 01-01- 18, Implementation: 07-02-18)

If the claim is denied because the beneficiary is under 35 years of age, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

CARC: 6
RARC: M37

Group Code: CO

If the claim is denied for a woman 35-39 because she has previously received this examination, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

CARC: 119
RARC: M89

Group Code: CO

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, the contractor shall use the following remittance advice

messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

CARC: 119
RARC: M90

Group Code: CO

If the claim is denied because the provider that performed the screening is not certified to perform the type of mammography billed (film or digital) the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

CARC: B7
RARC: N570

Group Code: CO

For claims that were submitted without the facility's FDA-assigned certification number, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

CARC: 16

RARC: MA128

Group Code: CO

For claims that were submitted with an invalid facility certification number, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

CARC: 16
RARC: MA128

Group Code: CO

30 - Screening Pap Smears
(Rev. 1, 10-01-03)

A3-3628.1, B3-4603.1, B3-4603.1A, SNF-541.2
Effective January 1, 1998, §1861(nn) of the Act (42 USC 1395x(nn)) provides Medicare Part B coverage for a screening Pap smear for women under certain conditions. See the Medicare Benefit Policy Manual, Chapter 15, for coverage of screening PAP smears.

To be covered screening Pap smears must be ordered and collected by a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act), or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under State law to perform the examination) under **one** of the conditions identified in §30.1, below.

30.1 - Pap Smears From January 1, 1998, Through June 30 2001
(Rev. 1, 10-01-03)

B3-4603.1A.1, B3-4603.1A.2, B3-4603.1A.3, A3-3628.1A

The following requirements must be met.

1. The beneficiary has not had a screening Pap smear test during the preceding three years (i.e., 35 months have passed following the month that the woman had the last covered Pap smear. Use one of the following ICD-9-CM codes V76.2, V76.47, or V76.49; **or**

2. There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years; **and** at least 11 months have passed following the month that the last covered Pap smear was performed; **or**

3. She is at high risk of developing cervical or vaginal cancer (use ICD-9-CM code V15.89, other specified personal history presenting hazards to health) **and** at least 11 months have passed following the month that the last covered screening Pap smear was performed. The high risk factors for cervical and vaginal cancer are:

    a. Cervical Cancer High Risk Factors:

        - Early onset of sexual activity (under 16 years of age)
        - Multiple sexual partners (5 or more in a lifetime)
        - History of a sexually transmitted disease (including HIV infection)
        - Fewer than three negative or any Pap smears within the previous 7 years

    b. Vaginal Cancer High Risk Factors:

        - DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

NOTE: The term "woman of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings.

COUNTING: To determine the 11-, 23-, and 35-month periods, start counts beginning with the month after the month in which a previous test/procedure was performed.

COUNTING EXAMPLE: A beneficiary identified as being at high risk for developing cervical cancer received a screening Pap smear in January 2000. Start counts beginning with February

2000. The beneficiary is eligible to receive another screening Pap smear in January 2001 (the month after 11 full months have passed).

30.2 - Pap Smears On and After July 1, 2001

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

If the beneficiary does not qualify for more frequent screening based on paragraphs (2) and (3) above, for services performed on or after July 1, 2001, payment may be made for a screening PAP smear after 23 months have passed after the end of the month of the last covered smear. All other coverage and payment requirements remain the same, except ICD-10-CM codes replace ICD-9-CM codes when mandated.

30.2.1 – Screening for Cervical Cancer with Human Papillomavirus (HPV) Testing

(Rev. 3460, Issued: 02-05-16, Effective: 07-09-16, Implementation: 03-07-16 - for non-shared MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement BR9434.04.8.2)

See the Medicare National Coverage Determinations (NCD) Manual, Pub 100-03, Section 210.2.1 for complete coverage requirements for screening for cervical cancer with Human Papillomavirus testing (HPV).

The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to add HPV testing once every five years as an additional preventive service benefit under the Medicare program for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test. CMS will cover screening for cervical cancer with the appropriate U.S. Food and Drug Administration (FDA)-approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations.

Effective for claims with dates of service on or after July 9, 2015, payment may be made for HCPCS G0476 (cervical cancer screening, all-inclusive HPV co-test with cytology (Pap smear) to detect HPV DNA or RNA sequences).

For claims with date of service from July 9, 2015 through December 31, 2016, HCPCS G0476 will be contractor priced. Beginning with date of service January 1, 2017 and after, HCPCS G0476 will be priced and paid according to the CLFS.

G0476 will be included in the January 2017 CLFS, January 1, 2016 IOCE, the January 2016 OPPS and January 1, 2016 MPFSD. HCPCS G0476 will be effective retroactive to July 9, 2015 in the IOCE & OPPS.

Effective for claims with dates of service on or after July 9, 2015, payment may be made for HCPCS G0476 (cervical cancer screening, all-inclusive HPV co-test with cytology (Pap smear) to detect HPV DNA or RNA sequences) only when submitted with a Place of Service Code equal to '81', Independent Lab or '11', Office.

A. Screening Pap Smears: A/B MAC (B) Action for Submitting Claims to the Common Working File (CWF) and CWF Edit

When a A/B MAC (B) receives a claim for a screening Pap smear, performed on or after January 1, 1998, it must enter a deductible indicator of 1 (not subject to deductible) in field 67 of the HUBC record.

CWF will edit for screening pelvic examinations performed more frequently than allowed according to the presence of high risk factors.

30.3 - Deductible and Coinsurance
(Rev. 1, 10-01-03)

B3-4603.4, A3-3628.1.A.3

Neither the Part B deductible nor coinsurance apply for services paid under the laboratory fee schedule. The Part B deductible for screening Pap smear and services paid for under the physician fee schedule is waived effective January 1, 1998. Coinsurance applies.

A. A/B MAC (B) Action for Submitting Claim to CWF and CWF Edit

B3-4603.4, B3-4603.6, B3-4603.1.B

When a A/B MAC (B) receives a claim for a screening Pap smear, performed on or after January 1, 1998, it must enter a deductible indicator of 1 (not subject to deductible) in field 67 of the HUBC record.

CWF will edit for screening pelvic examinations performed more frequently than allowed according to the presence of high risk factors.

30.4 - Payment Method
(Rev. 1, 10-01-03)

B3-4603.1.C.1 and 2
Payment may be under the clinical diagnostic lab fee schedule or the MPFS, depending upon the code billed. See the categories in §30.5 of this chapter for a description.

30.4.1 - Payment Method for RHCs and FQHCs
(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The professional component of a screening Pap smear furnished within an RHC/FQHC by a physician or non physician is considered an RHC/FQHC service. RHCs and FQHCs bill the A/B MAC (A) under bill type 71X or 73X for the professional component along with revenue code 052X. See Chapter 9, for RHC and FQHC bill processing instructions.

The technical component of a screening Pap smear is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the A/B MAC (B) on Form CMS-1500.

If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the A/B MAC (A) under bill type 13X, 14X, 22X, 23X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider

number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 311. Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.

30.5 - Screening Pap Smears: Healthcare Common Procedure Coding System (HCPCS) Codes for Billing

(Rev. 3460, Issued: 02-05-16, Effective: 07-09-16, Implementation: 03-07-16 - for non-shared MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement BR9434.04.8.2)

The following HCPCS codes can be used for screening Pap smear:

A. Screening Pap Smears: Codes Billed to the A/B MAC (B) and Paid Under the Medicare Physician Fee Schedule (MPFS)

The following HCPCS codes are submitted by those providers/entities that submit claims to A/B MACs (B). The deductible is waived for these services effective January 1, 1998, however, coinsurance applies.

NOTE: These codes are not billed on A MAC claims except for HCPCS Q0091 which may be submitted to A/B MACs (B). Payment for HCPCS Q0091 performed in a hospital outpatient department is under the outpatient prospective payment system (OPPS) (see 30.5C).

- Q0091 - Screening Papanicolaou (Pap) smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory;

- P3001 - Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by a physician;

- G0124 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician; and

- G0141 - Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual re-screening, requiring interpretation by physician.

B. Screening Pap Smears: Codes Paid Under the Clinical Lab Fee Schedule by A/B MACs

The following codes are billed to A/B MACs (A) by providers they serve, or billed to A/B MACs (B) by the physicians/suppliers they service. Deductible and coinsurance do not apply.

- P3000 - Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision;

- G0123 - Screening cytopathology, cervical or vaginal (any reporting system) collected in preservative fluid; automated thin layer preparation, screening by cytotechnologist under physician supervision;

- G0143 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and re-screening, by cytotechnologist under physician supervision;

- G0144 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system under physician supervision;

- G0145 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual re-screening under physician supervision;

- G0147 - Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision; and

- G0148 - Screening cytopathology smears, cervical or vaginal, performed by automated system with manual reevaluation.

C. Screening Pap Smears: Payment of Q0091 When Billed to A/B MACs (B)

Payment for HCPCS Q0091 in a hospital outpatient department is under OPPS. A skilled nursing facility (SNF) is paid using the technical component of the MPFS. For a critical access hospital (CAH), payment is on a reasonable cost basis. For rural health clinics/Federally qualified health centers (RHC/FQHCs) payment is made under the all-inclusive rate for the professional component. Deductible is not applicable, however, coinsurance applies.

The technical component of a screening Pap smear is outside the RHC/FQHC benefit. If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the A MAC under type of bill (TOB) 13X, 14X, 22X, 23X, or 85X as appropriate using their base provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). For independent RHCs/FQHCs, the practitioner bills the technical component to the A/B MACs (B) on Form CMS-1500 or the ANSI X12N 837 P. Effective April 1, 2006, TOB 14X is for non-patient laboratory specimens.

D. Screening Pap Smears: Payment of HCPCS Q0091 When Billed to A/B MACs (B)

Payment for HCPCS Q0091 is paid under the MPFS. Deductible is not applicable, however the coinsurance applies.

Effective for claims with dates of service on and after July 1, 2005, on those occasions when physicians must perform a screening Pap smear (HCPCS Q0091) that they know will not be covered by Medicare because the low-risk patient has already received a covered Pap smear (HCPCS Q0091) in the past 2 years, the physician can bill HCPCS Q0091 and the claim will be denied appropriately. The physician shall obtain an advance beneficiary notice (ABN) in these situations as the denial will be considered a not reasonable and necessary denial. The physician indicates on the claim that an ABN has been obtained by using the GA modifier.

Effective for claims with dates of service on or after April 1, 1999, a covered evaluation and management (E/M) visit and HCPCS Q0091 may be reported by the same physician for the same date of service if the E/M visit is for a separately identifiable service. In this case, the modifier "-25" must be reported with the E/M service and the medical records must clearly document the E/M reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately on separate office visits.

E. Screening Pap Smears: CWF Editing for HCPCS Q0091

The CWF will edit for claims containing HCPCS Q0091 effective for dates of service on and after July 1, 2005. Previously, the editing for HCPCS Q0091 had been removed from the CWF. Medicare pays for a screening Pap smear every 2 years for low-risk patients based on the low-risk diagnoses, see sections 30.2 and 30.6. Medicare pays for a screening Pap smear every year for a high-risk patient based on the high-risk diagnosis, see sections 30.1 and 30.6. This criteria will be the CWF parameters for editing HCPCS Q0091.

In those situations where unsatisfactory screening Pap smear specimens have been collected and conveyed to clinical labs that are unable to interpret the test results, another specimen will have to be collected. When the physician bills for this reconveyance, the physician should annotate the claim with HCPCS Q0091 along with modifier -76, (repeat procedure by same physician).

30.6 - Screening Pap Smears: Diagnoses Codes

(Rev. 11445, Issued:06-03-22 Effective:05-09-22, Implmentation:05-09-22)

Effective October 1, 2015 the below are the current diagnoses that should be used when billing for screening Pap smear services

The following chart lists the diagnosis codes that CWF must recognize for high-risk patients for every year screening Pap smear services.

ICD-10-CM Codes for PAP High Risk every year

ICD-10 CM code	Definitions
Z77.29	Contact with and (suspected) exposure to other hazardous substances
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior
Z77.9	Other contact with and (suspected) exposures hazardous to health
Z91.89	Other specified personal risk factors, not elsewhere classified
Z92.850	Personal history of Chimeric Antigen Receptor T-cell therapy
Z92.858	Personal history of other cellular therapy
Z92.86	Personal history of gene therapy
Z92.89	Personal history of other medical treatment

The following chart lists the diagnosis codes that CWF must recognize for low-risk for every 2 years

ICD-10-CM Codes for PAP Low Risk every 2 years

ICD-10 CM code	Definitions

Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Z12.4	Encounter for screening for malignant neoplasm of cervix
Z12.72	Encounter for screening for malignant neoplasm of vagina
Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Z12.89	Encounter for screening for malignant neoplasm of other sites

A. Screening Pap Smears: Applicable Diagnoses for Billing A/B MAC (B)

There are a number of appropriate diagnosis codes that can be used in billing for screening Pap smear services that the provider can list on the claim to give a true picture of the patient's condition. Those diagnoses can be listed in Item 21 of Form CMS-1500 or the electronic equivalent (see Chapter 26 for electronic equivalent formats). In addition, one of the following diagnoses shall appear on the claim: the low-risk diagnosis of Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89 or the high-risk diagnosis of, Z77.29, Z72.51, Z72.52, Z72.53, Z77.9, Z91.89, Z92.850, Z92.858, Z92.86, and Z92.89. (Effective Oct 1, 2015) One of the above diagnoses must be listed in item 21of the Form CMS-1500 or the electronic equivalent to indicate either low risk or high risk depending on the patient's condition. Then either the low-risk or high-risk diagnosis must also be pointed to in Item 24E of Form CMS-1500 or the electronic equivalent. Providers must make sure that for screening Pap smears for a high-risk beneficiary that the high-risk diagnosis code appears in Item 21 that must be pointed to in Item 24E or the electronic equivalent. If Pap smear claims do not point to one of these specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. **Periodically, A/B MACs (B) should do provider education on diagnosis coding of Pap smear claims.**

B. Screening Pap Smears: Applicable Diagnoses for Billing A/B MACs (A)

Providers report one of the following diagnosis codes in Form CMS-1450 or the electronic equivalent (**NOTE:** Information regarding the form locator numbers that correspond to the diagnosis codes and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.):

Low-risk ICD-10-diagnosis codes for every 2 years:

Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Z12.4	Encounter for screening for malignant neoplasm of cervix
Z12.72	Encounter for screening for malignant neoplasm of vagina
Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Z12.89	Encounter for screening for malignant neoplasm of other sites

High-risk ICD-10 diagnosis codes for every year:

ICD-10 CM code	**Definitions**

Z77.29	Contact with and (suspected) exposure to other hazardous substances
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior
Z77.9	Other contact with and (suspected) exposures hazardous to health
Z91.89	Other specified personal risk factors, not elsewhere classified
Z92.850	Personal history of Chimeric Antigen Receptor T-cell therapy
Z92.858	Personal history of other cellular therapy
Z92.86	Personal history of gene therapy
Z92.89	Personal history of other medical treatment

Periodically provider education should be done on diagnosis coding of Pap smear claims.

C. HPV Screening: Applicable Diagnoses for Billing A/B MAC (A/B)

Effective for claims with dates of service on or after July 9, 2015, providers shall report the following diagnosis codes when submitting claims for HCPCS G0476 - Cervical cancer screening, all-inclusive HPV co-test with cytology (Pap smear) to detect HPV DNA or RNA sequences:

ICD-10: Z11.51, encounter for screening for HPV, and Z01.411, encounter for gynecological exam (general)(routine) with abnormal findings, OR, Z01.419, encounter for gynecological exam (general)(routine) without abnormal findings.

30.7 - TOB and Revenue Codes for Form CMS-1450

(Rev. 3460, Issued: 02-05-16, Effective: 07-09-16, Implementation: 03-07-16 - for non-shared MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement BR9434.04.8.2)

The applicable bill types for screening Pap smears are 12X, 13X, 14X, 22X, 23X, and 85X. Use revenue code 0311 (laboratory, pathology, cytology). Report the screening pap smear as a diagnostic clinical laboratory service using one of the HCPCS codes shown in §30.5.B.

In addition, CAHs electing method II report professional services under revenue codes 096X, 097X, or 098X.

Effective April 1, 2006, TOB 14X is for non-patient laboratory specimens.

HPV Screening: Effective for claims with dates of service on and after July 9, 2015, HCPCS G0476, Cervical cancer screening, all-inclusive HPV co-test with cytology (Pap smear) to detect HPV DNA or RNA sequences, shall be paid only on TOBs 12X, 13X, 14X, 22X, 23X, and 85X.

30.8 - MSN Messages

(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

If there are no high risk factors, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed use MSN 18.17:

Medicare pays for a screening Pap smear and/or screening pelvic examination only once every (2, 3) years unless high risk factors are present.

HPV Screening: Effective for claims with dates of service on and after July 9, 2015:

A. If denying line-items on claims containing HCPCS G0476, HPV screening, when reported more than once in a 5-year period [at least 4 years and 11 full months (59 months total) must elapse from the date of the last screening], use the following messages:

(Part A Only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD 210.2.1 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD 210.2.1 fueron utilizadas cuando se tomó esta decisión."

B. If denying line-items on claims containing HCPCS G0476, HPV screening, when the beneficiary is not between the ages of 30-65, use the following messages:

(Part A Only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD 210.2.1 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD 210.2.1 fueron utilizadas cuando se tomó esta decisión."

C. If denying line-items on claims containing HCPCS G0476, HPV screening, when the claim does not contain the appropriate ICD-10 diagnosis codes listed below:

ICD-10: Z11.51 and Z01.411 or, Z01.419

Use the following messages:

(Part A Only)MSN 15.19: “Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD”.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: “The following policies NCD 210.2.1 were used when we made this decision.”

Spanish Version – “Las siguientes políticas NCD 210.2.1 fueron utilizadas cuando se tomó esta decisión.”

30.9 - Remittance Advice Codes

(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

Pap Smear Screening: If high risk factors are not present, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, use existing ANSI X12N 835:

- Claim adjustment reason code 119 - “Benefit maximum for this time period has been reached” at the line level, and

- Remark code M83 - “Service is not covered unless the patient is classified as at high risk” at the line item level.

HPV Screening: Effective for claims with dates of service on and after July 9, 2015:

A. If denying line-items on claims containing HCPCS G0476, HPV screening, when reported more than once in a 5-year period [at least 4 years and 11 months (59 months total) must elapse from the date of the last screening], use the following messages:

CARC 119: “Benefit maximum for this time period or occurrence has been reached.”

RARC N386: “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

B. If denying line-items on claims containing HCPCS G0476, HPV screening, when the beneficiary is not between the ages of 30-65, use the following messages:

CARC 6: “The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

RARC N129: “Not eligible due to the patient’s age.”

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

C. If denying line items on claims containing HCPCS G0476, HPV screening, when the claim does not contain the appropriate ICD-10 diagnosis codes listed below:

ICD-10: Z11.51 and Z01.411, or, Z01.419

Use the following messages:

CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

Group Code CO assigning financial liability to the provider

40 - Screening Pelvic Examinations

(Rev. 1541, Issued: 06-20-08, Effective: 09-23-08, Implementation: 09-23-08)

Section 4102 of the BBA of 1997 (P.L. 105-33) amended §1861(nn) of the Act (42 USC 1395X(nn)) to include Medicare Part B coverage of screening pelvic examinations (including a clinical breast examination) for all female beneficiaries for services provided January 1, 1998 and later. Effective July 1, 2001, the Consolidated Appropriations Act of 2001 (P.L. 106-554) modifies §1861(nn) to provide Medicare Part B coverage for biennial screening pelvic examinations. A screening pelvic examination with or without specimen collection for smears and cultures, should include at least seven of the following eleven elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;
- External genitalia (for example, general appearance, hair distribution, or lesions);
- Urethral meatus (for example, size, location, lesions, or prolapse);
- Urethra (for example, masses, tenderness, or scarring);

- Bladder (for example, fullness, masses, or tenderness);
- Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
- Cervix (for example, general appearance, lesions or discharge)
- Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
- Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); and
- Anus and perineum.

40.1 - Screening Pelvic Examinations From January 1, 1998, Through June 30 2001

(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

B3-4603.2.A, B3-4603.5, A3-3628.1.B.1, R1888.A.3 Dated 6-3-2003

The following requirements must be met.

The exam must be performed by a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act), or by a certified nurse midwife (as defined in §1861(gg) of the Act), or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in §1861(aa) of the Act) who is authorized under State law to perform the examination. This examination does not have to be ordered by a physician or other authorized practitioner.

Payment may be made: Once every three years on an asymptomatic woman only if the individual has not had a screening pelvic examination paid for by Medicare during the preceding 35 months following the month in which the last Medicare-covered screening pelvic examination was performed. Providers use ICD-10-CM codes for the low risk factors. Exceptions are as follows:

- Payment may be made for a screening pelvic examination performed more frequently than once every 35 months if the test is performed by a physician or other practitioner and there is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical cancer, or vaginal cancer. Providers use ICD-10-CM codes for the high risk factors for cervical and vaginal cancer are:

  Cervical Cancer High Risk Factors

  - Early onset of sexual activity (under 16 years of age)
  - Multiple sexual partners (five or more in a lifetime)
  - History of a sexually transmitted disease (including HIV infection)
  - Fewer than three negative or any Pap smears within the previous seven years

  Vaginal Cancer High Risk Factors

- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

ICD-10-CM code Z92.89, Personal history of other medical treatment is used to indicate that one or more of these factors is present; or

- Payment may also be made for a screening pelvic examination performed more frequently than once every 36 months if the examination is performed by a physician or other practitioner, for a woman of childbearing age, who has had such an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding three years. The term "women of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings. Payment is not made for a screening pelvic examination for women at high risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after the month that the last screening pelvic examination covered by Medicare was performed.

- For claims with dates of service on or after July 1, 2001, if the beneficiary does not qualify for an annual screening pelvic exam as noted above, pay for the screening pelvic exam only after at least 23 months have passed following the month during which the beneficiary received her last covered screening pelvic exam. All other coverage and payment requirements remain the same.

Calculating the Frequency Limitations

To determine the screening periods, start counts beginning with the month after the month in which a previous test/procedure was performed.

Frequency Limitation Example

A beneficiary identified as being at high risk for developing cervical cancer received a pelvic exam in January 2002. Start counts beginning with February 2002. The beneficiary is eligible to receive another screening exam, if high risk, in January 2003 (the month after 11 full months have passed).

40.2 - Screening Pelvic Examinations on and After July 1, 2001
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

When the beneficiary does not qualify for a more frequently performed screening pelvic exam noted in §40.1 of this chapter, items 2, or 3, the screening pelvic exam may be paid only after at least 23 months have passed following the month during which the beneficiary received her last covered screening pelvic exam. All other coverage, claim preparation, and payment requirements remain the same, except ICD-10-CM codes replace ICD-9-CM codes when mandated.

40.3 - Deductible and Coinsurance
(Rev. 1, 10-01-03)

B3-4603.2.C, A3-3628.1.B.3

The Part B deductible for screening pelvic examinations is waived effective January 1, 1998. Coinsurance is applicable.

A. Action When Submitting Claims to CWF and CWF Edit

B3-4603.4, B3-4603.6, A3-3628.1.C.1

When an A/B MAC (B) receives a claim for a pelvic examination, performed on or after January 1, 1998, it must enter a deductible indicator of 1 (not subject to deductible) in field 65 of the HUBC record.

When an A/B MAC (A) receives a claim for a screening pelvic examination (including a clinical breast examination), performed on or after January 1, 1998, it reports special override Code 1 in the "Special Action Code/Override Code" field of the CWF record for the line item, indicating the Part B deductible does not apply.

CWF edits for screening pelvic examinations performed more frequently than allowed according to the presence of high risk factors.

40.4 - Diagnoses Codes

(Rev. 11445, Issued:06-03-22 Effective:05-09-22, Implmentation:05-09-22)

Below are the current diagnoses that should be used when billing for screening pelvic examination services. Effective Oct 1, 2015 the following chart lists for the ICD-10-CM codes that CWF must recognize for low risk or high-risk patients for screening pelvic examination services.

Low Risk Diagnosis Codes

ICD-10-CM codes	Description
Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Z12.4	Encounter for screening for malignant neoplasm of cervix
Z12.72	Encounter for screening for malignant neoplasm of vagina
Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Z12.89	Encounter for screening for malignant neoplasm of other sites

High Risk Diagnosis Codes

ICD-10-CM codes	Description
Z77.9	Other contact with and (suspected) exposures hazardous to health
Z77.29	Contact with and (suspected) exposure to other hazardous substances

ICD-10-CM codes	Description
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior
Z91.89	Other specified personal risk factors, not elsewhere classified
Z92.850	Personal history of Chimeric Antigen Receptor T-cell therapy
Z92.858	Personal history of other cellular therapy
Z92.86	Personal history of gene therapy
Z92.89	Personal history of other medical treatment

A. Applicable Diagnoses for Billing an A/B MAC (B)

For professional claims, providers report diagnosis codes according to the instructions in the ASC X12 837 professional claim technical report 3 for electronic claims and chapter 26 of this manual for paper claims. Part of this reporting includes pointing (relating) the claimed service to a diagnosis code on the claim.

There are a number of appropriate diagnosis codes that can be used in billing for screening pelvic examinations that the provider can list on the claim to give a true picture of the patient's condition. In addition, one of the diagnoses listed in either the high risk or low risk tables above (§40.4) must be on the claim to indicate either low risk or high risk depending on the patient's condition, and the screening pelvic examination service must point to this diagnosis code. Providers must make sure that, for screening pelvic exams for a high risk beneficiary, a high risk diagnosis code appears on the claim and that the screening pelvic examination service points to this diagnosis code. If pelvic examination claims do not point to one of these specific diagnoses, the claim will reject in the CWF. If these pointers are not present on claims submitted to A/B MACs (B), CWF will reject the record.

Periodically, A/B MACs (B) should do provider education on diagnosis coding of screening pelvic examination claims.

B. Applicable Diagnoses for Billing an A/B MAC (A)

For institutional claims, providers report diagnosis codes according to the instructions in the ASC X12 837 institutional claim technical report 3 for electronic claims and chapter 25 of this manual for paper claims. (Chapter 25 also contains additional general billing information for institutional claims.)

Appropriate diagnoses are shown above in this section for low risk and high risk beneficiaries.

Periodically provider education should be done on diagnosis coding of screening pelvic exam claims.

40.5 - Payment Method
(Rev 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

Pelvic examinations are paid under the MPFS, whether billed to the A/B MAC (A) or (B) **except**:

- Hospital outpatient services are paid under OPPS;

- See §40.5.B of this chapter for proper billing by RHC/FQHCs for the professional and technical components of a screening pelvic examination. RHCs/FQHCs are paid under the all-inclusive rate for the professional component; or based on the provider's payment method for the technical component;

- CAH payment is under reasonable cost.

NOTE: SNFs are paid under the MPFS and bill the A/B MAC (A). Physicians and other individual practitioners bill the A/B MAC (B).

40.6 - Revenue Code and HCPCS Codes for Billing
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

A. Billing to the A/B MAC (B)

Code G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination) is used.

Effective for services on or after January 1, 1999, a covered evaluation and management (E/M) visit and code G0101 may be reported by the same physician for the same date of service if the E/M visit is for a separately identifiable service. In this case, the modifier "-25" must be reported with the E/M service and the medical records must clearly document the E/M service reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately on separate office visits.

B. Billing to the A/B MAC (A)

The applicable bill types for a screening pelvic examination (including breast examination) are 12X, 13X, 22X, 23X, and 85X. The applicable revenue code is 0770. (See §70.1.1.2 for RHCs and FQHCs.) Effective April 1, 2006, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for a screening pelvic examination.

The professional component of a screening pelvic examination furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the A/B MAC (A) under bill type 71X or 73X for the professional component along with revenue code 052X.

The technical component of a screening pelvic examination is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the A/B MAC (B) on the ASC X12 837 professional claim format or hardcopy Form CMS-1500.

If the technical component of a screening pelvic examination is furnished within a provider-based RHC/FQHC, the provider of that service bills the A/B MAC (A) under bill type 12X, 13X, 22X, 23X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 0770. Effective April 1, 2006, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for a screening pelvic examination.

40.7 - MSN Messages
(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

If there are no high risk factors, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, A/B MACs (A) and (B) use MSN 18.17:

- Medicare pays for a screening Pap smear and/or screening pelvic examination only once every (2, 3) years unless high risk factors are present.

40.8 - Remittance Advice Codes
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

If high risk factors are not present, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, use existing ASC X12 835:

- Claim adjustment reason code 119 - "Benefit maximum for this time period has been reached" at the line level, and

- Remark code M83 - "Service is not covered unless the patient is classified as at high risk" at the line item level.

50 - Prostate Cancer Screening Tests and Procedures
(Rev. 1, 10-01-03)

B3-4182, A3-3616

Sections 1861(s)(2)(P) and 1861(oo) of the Act (as added by §4103 of the Balanced Budget Act of 1997), provide for Medicare Part B coverage of certain prostate cancer screening tests subject to certain coverage, frequency, and payment limitations. Effective for services furnished on or after January 1, 2000, Medicare Part B covers prostate cancer screening tests/procedures for the early detection of prostate cancer. Coverage of prostate cancer screening tests includes the following procedures furnished to an individual for the early detection of prostate cancer:

- Screening digital rectal examination, and

- Screening prostate specific antigen (PSA) blood test.

Each test may be paid at a frequency of once every 12 months for men who have attained age 50 (i.e., starting at least one day after they have attained age 50), if at least 11 months have passed following the month in which the last Medicare-covered screening digital rectal examination was performed (for digital rectal exams) or PSA test was performed (for PSA tests).

50.1 - Definitions
(Rev. 1, 10-01-03)
A3-3616.A.1 and 2

A. Screening Digital Rectal Examination

Screening digital rectal examination means a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate. This screening must be performed by a doctor of medicine or osteopathy (as defined in §186l(r)(1) of the Act), or by a physician assistant, nurse practitioner, clinical nurse specialist, or by a certified nurse mid-wife (as defined in §1861(aa) and §1861(gg) of the Act), who is authorized under State law to perform the examination, fully knowledgeable about the beneficiary, and would be responsible for explaining the results of the examination to the beneficiary.

B. Screening Prostate Specific Antigen (PSA) Tests

Screening prostate specific antigen (PSA) is a test that measures the level of prostate specific antigen in an individual's blood. This screening must be ordered by the beneficiary's physician or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife (the term "physician" is defined in §1861(r)(1) of the Act to mean a doctor of medicine or osteopathy and the terms "physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife" are defined in §1861(aa) and §1861(gg) of the Act) who is fully knowledgeable about the beneficiary, and who would be responsible for explaining the results of the test to the beneficiary.

50.2 - Deductible and Coinsurance
(Rev. 1, 10-01-03)

B3-4182.3

The screening PSA test is a lab test to which neither deductible nor coinsurance apply.
Both deductible (if unmet) and coinsurance are applicable to screening rectal examinations.

50.3 - Payment Method - A/B MACs (A) and (B)
(Rev. 11902; Issued:03-16-23; Effective: 04-17-23; Implementation: 04-17-23)

Screening PSA tests (G0103) are paid under the clinical diagnostic lab fee schedule.

Screening PSA tests (Effective 01/01/23 (0359U)) new codes are contractor-priced (where applicable) until they are nationally priced and undergo the CLFS annual payment determination process.
Screening rectal examinations (G0102) are paid under the MPFS except for the following bill types identified (A/B MAC (A) only). Bill types not identified are paid under the MPFS.

12X = Outpatient Prospective Payment System
13X = Outpatient Prospective Payment System
14X-=Outpatient Prospective Payment System
71X = Included in All Inclusive Rate
73X = Included in All Inclusive Rate

85X = Cost (Payment should be consistent with amounts paid for code 84153 or code 86316.)

Effective 4/1/06 the type of bill 14X is for non-patient laboratory specimens.

The RHCs and FQHCs should include the charges on the claims for future inclusion in encounter rate calculations.

50.3.1 - Correct Coding Requirements for A/B MAC (B) Claims
(Rev. 1, 10-01-03)

B3-4182.6

Billing and payment for a Digital Rectal Exam (DRE) (G0102) is bundled into the payment for a covered E/M service (CPT codes 99201 - 99456 and 99499) when the two services are furnished to a patient on the same day. If the DRE is the only service or is provided as part of an otherwise noncovered service, HCPCS code G0102 would be payable separately if all other coverage requirements are met.

50.4 - HCPCS, Revenue, and Type of Service Codes
(Rev. 11902; Issued:03-16-23; Effective: 04-17-23; Implementation: 04-17-23)

The appropriate bill types for billing the A/B MAC (A) on Form CMS-1450 or its electronic equivalent are 12X, 13X, 14X, 22X, 23X, 71X, 73X, 75X, and 85X. Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.

The HCPCS code G0102 - for prostate cancer screening digital rectal examination.

- A/B MAC (B) TOS is 1
- A/B MAC (A) revenue code is 0770

The HCPCS code G0103 - for prostate cancer screening PSA tests

- A/B MAC (B) TOS is 5
- A/B MAC (A) revenue code is 030X

The HCPCS code 0359U – (PROSTATE CANCER), ANALYSIS OF ALL PROSTATE-SPECIFIC ANTIGEN (PSA) STRUCTURAL ISOFORMS BY PHASE SEPARATION AND IMMUNOASSAY, PLASMA, ALGORITHM REPORTS RISK OF CANCER. Effective 01/01/23.

- A/B MAC (B) TOS is 5
- A/B MAC (A) revenue code is 030X

50.5 - Diagnosis Coding
(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

Prostate cancer screening digital rectal examinations and screening Prostate Specific Antigen (PSA) blood tests must be billed using either screening code if ICD-10-CM is applicable, diagnosis code Z12.5 (Encounter for screening for malignant neoplasm of prostate).

50.6 - Calculating Frequency
(Rev. 1, 10-01-03)

A3-3616.D and E, B3-4182.4, B3-4182.5

Calculating Frequency - To determine the 11-month period, the count starts beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received a screening prostate specific antigen test in January 2002. Start counts beginning February 2002. The beneficiary is eligible to receive another screening prostate specific antigen test in January 2003 (the month after 11 months have passed).

Common Working File (CWF) Edits

Beginning October 1, 2000, the following CWF edits were implemented for dates of service January 1, 2000, and later, for prostate cancer screening tests and procedures for the following:

- Age;
- Frequency;
- Sex; and
- Valid HCPCS code.

50.7 - MSN Messages
(Rev. 1, 10-01-03)

B3-4182.8.B, A3-3616.F

If a claim for screening prostate specific antigen test or a screening digital rectal examination is being denied because of the age of the beneficiary, A/B MACs (A) use MSN message 18.13:

> This service is not covered for patients under 50 years of age.

The Spanish version of this MSN message should read:

> Este servicio no está cubierto hasta después de que el beneficiario cumpla 50 años.

A/B MACs (B) use MSN Message 18.19:

> This service is not covered until after the patient’s 50th birthday.

The Spanish version of this MSN message should read:

> Este servicio no está cubierto hasta después de que el beneficiario cumpla 50 años.

If the claim for screening prostate specific antigen test or screening digital rectal examination is being denied because the time period between the same test or procedure has not passed, A/B MACs (A) and (B) use MSN message 18.14:

> Service is being denied because it has not been 12 months since your last test/procedure) of this kind.

The Spanish version of this MSN message should read:

> Este servicio está siendo denegado ya que no han transcurrido (12, 24, 48) meses desde el último (examen/procedimiento) de esta clase.

50.8 - Remittance Advice Notices

(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

If the claim for a screening prostate antigen test or screening digital rectal examination is being denied because the patient is less than 50 years of age, use the ASC X12 835 with

- Claim adjustment reason code; 6 "the procedure/revenue code is inconsistent with the patient's age," at the line level; and

- Remark code M82 "Service not covered when patient is under age 50."

If the claim for a screening prostate specific antigen test or screening digital rectal examination is being denied because the time period between the test/procedure has not passed, A/B MACs (A) and (B) use ASC X12 835 claim adjustment reason code 119, "Benefit maximum for this time period has been reached" at the line level.

If the claim for a screening prostate antigen test or screening digital rectal examination is being denied due to the absence of ICD-10-CM diagnosis code Z12.5 on the claim, use the ASC X12 835 claim adjustment reason code 167 – This (these) diagnosis(es) is (are) not covered.

RARC N386 – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

60 - Colorectal Cancer Screening

(Rev. 10818; Issued: 05-20-21; Effective: 01-09-21; Implementation: 10-04-21)

See the Medicare Benefit Policy Manual, Chapter 15, and the Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Section 210.3 for Medicare Part B coverage requirements and effective dates of colorectal cancer screening services.

Effective for services furnished on or after January 1, 1998, payment may be made for colorectal cancer screening for the early detection of cancer. For screening colonoscopy services (one of the types of services included in this benefit) prior to July 2001, coverage was limited to high-risk individuals. For services July 1, 2001, and later, screening colonoscopies are covered for individuals not at high risk.

The following services are considered colorectal cancer screening services:

- Fecal-occult blood test (FOBT),1-3 simultaneous determinations (guaiac-based);
- Flexible sigmoidoscopy;
- Colonoscopy; and,
- Barium enema

Effective for services on or after January 1, 2004, payment may be made for the following colorectal cancer screening service as an alternative for the guaiac-based FOBT, 1-3 simultaneous determinations:

- FOBT, immunoassay, 1-3 simultaneous determinations

Effective for services on or after October 9, 2014, payment may be made for colorectal cancer screening using the Cologuard™ multi-target sDNA test:

- HCPCS G0464 (Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3).

  Note: HCPCS code G0464 expired on December 31, 2015, and has been replaced in the 2016 CLFS with CPT code 81528, Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result, effective January 2, 2016**.**

Effective for services on or after January 19, 2021, payment may be made for colorectal cancer using Blood-based DNA Testing:

- Blood-based Biomarker Test, HCPCS G0327, effective July 1, 2021

60.1 - Payment

(Rev. 10818; Issued: 05-20-21; Effective: 01-09-21; Implementation: 10-04-21)

Payment is under the MPFS except as follows:

- FOBTs [CPT 82270* (HCPCS G0107*) and HCPCS G0328] are paid under the CLFS except reasonable cost is paid to all non-outpatient prospective payment system (OPPS) hospitals, including Critical Access Hospitals (CAHs), but not Indian Health Service (IHS) hospitals billing on type of bill (TOB) 83X. IHS hospitals billing on TOB 83X are paid the Ambulatory Surgery Center (ASC) payment amount. Other IHS hospitals (billing on TOB 13X) are paid the Office of Management and Budget (OMB)-approved all-inclusive rate (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 hospitals on TOB 13X. Payment to all hospitals for non-patient laboratory specimens on TOB 14X will be based on the CLFS, including CAHs and Maryland waiver hospitals.

- For claims with dates of service on or after January 1, 2015, through December 31, 2015, the Cologuard™ multi-target sDNA test (HCPCS G0464) is paid under the CLFS.

  Note: For claims with dates of service October 9, 2014, thru December 31, 2014, HCPCS code G0464 is paid under local contractor pricing.

- For claims with dates of service on or after January 1, 2016, CPT code 81528 replaces G0464 is paid under the CLFS.

- For claims with dates of service on or after January 19, 2021, Blood-based Biomarker test (HCPCS G0327) is paid under the CLFS

- 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 (HCPCS G0105 and G0121) and barium enemas (HCPCS G0106 and G0120) are 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. Also colonoscopies may be performed in an 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.

The following screening codes must be paid at rates consistent with the rates of the diagnostic codes indicated. Coinsurance and deductible apply to diagnostic codes.

HCPCS Screening Code	**HCPCS 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 G0104, G0105, G0106, 82270* (G0107*), G0120, G0121, G0328, G0464, and 81528 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 All Hospitals

Payment for colorectal cancer screenings (CPT 82270* (HCPCS G0107*), HCPCS G0328, and G0464 (Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528) 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 G0107. Effective January 1, 2007, HCPCS G0107 was discontinued and replaced with CPT 82270.

60.1.1 – Deductible and Coinsurance

(Rev. 12299; Issued:10-12-23; Effective:01-01-23; Implementation:11-13-23)

There is no deductible and no coinsurance or copayment for the FOBTs (HCPCS G0107, G0328), flexible sigmoidoscopies (G0104), colonoscopies on individuals at high risk (HCPCS G0105), or colonoscopies on individuals not meeting criteria of high risk (HCPCS G0121).

Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the -PT modifier; and the deductible is waived. Prior to January 1, 2022, when a screening colonoscopy became a diagnostic, the beneficiary was liable for the full applicable coinsurance. However, Section 122 of Division CC of the Consolidated Appropriations Act

(CAA) of 2021, Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests, amended section 1833(a) of the Social Security Act to offer a special coinsurance rule for screening flexible sigmoidoscopies and screening colonoscopies, regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure, that is furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test. Consequently, the applicable coinsurance in these specific scenarios will be gradually reduced until it is completely waived for dates of service on or after January 1, 2030. Specifically, for dates of service in CY 2023 through CY 2026, when the PT modifier is appended to at least one code on the claim to indicate that a screening colorectal cancer procedure, HCPCS G0104, G0105, or G0121, has become a diagnostic or therapeutic service, contractors shall continue to waive deductible and shall apply a reduced coinsurance of 15% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service in CY 2027 through CY 2029, contractors shall continue to waive deductible and shall apply a reduced coinsurance of 10% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service on or after January 1, 2030, contractors shall continue to waive deductible and shall waive coinsurance for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim.

Coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier -33. When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (G0500 or 99153) are reported with only the -PT modifier; only the deductible is waived.

Prior to January 1, 2007 deductible and coinsurance apply to other colorectal procedures (HCPCS G0106 and G0120). After January 1, 2007, the deductible is waived for those tests. Coinsurance applies.

Effective for claims with dates of service on and after October 9, 2014, deductible and coinsurance do not apply to the Cologuard™ multi-target sDNA screening test (HCPCS G0464). (Note: Beginning January 1, 2016, CPT code 81528 replaced G0464).

Effective for claims with dates of service on and after January 19, 2021, deductible and coinsurance do not apply to the Blood-based biomarker test (HCPCS G0327).

Effective for claims with dates of service on or after January 1, 2023, colorectal cancer screening tests include a screening colonoscopy (HCPCS codes G0105, G0121) that follows a non-invasive stool- based test (HCPCS codes 82270, G0328 and 81528). This scenario shall be identified by the furnishing practitioner by including the KX modifier on the screening colonoscopy claim. Deductible and coinsurance do not apply to the non-invasive stool-based tests nor the screening colonoscopy because both tests are specified preventive screening services.

NOTE: A 25% coinsurance applies for all colorectal cancer screening colonoscopies (HCPCS G0105 and G0121) performed in ASCs and non-OPPS hospitals effective for services performed on or after January 1, 2007. The 25% coinsurance was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

A 25% coinsurance also applies for colorectal cancer screening sigmoidoscopies (HCPCS G0104) performed in non-OPPS hospitals effective for services performed on or after January 1, 2007. Beginning January 1, 2008, colorectal cancer screening sigmoidoscopies (HCPCS G0104) are payable in ASCs, and a 25% coinsurance applies. The 25% coinsurance for colorectal cancer screening sigmoidoscopies was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

Effective for claims with dates of service on or after January 1, 2011, coinsurance and deductible do not apply to screening colonoscopies, screening sigmoidoscopies, and other specified colorectal cancer screening services.

60.2 - HCPCS Codes, Frequency Requirements, and Age Requirements

(Rev. 12299; Issued:10-12-23; Effective:01-01-23; Implementation:11-13-23)

Effective for services furnished on or after January 1, 1998, the following codes are used for colorectal cancer screening services:

- CPT 82270* (HCPCS G0107*) - Colorectal cancer screening; fecal-occult blood tests, 1-3 simultaneous determinations;
- HCPCS G0104 - Colorectal cancer screening; flexible sigmoidoscopy;
- HCPCS G0105 - Colorectal cancer screening; colonoscopy on individual at high risk;
- HCPCS G0106 - Colorectal cancer screening; barium enema; as an alternative to HCPCS G0104, screening sigmoidoscopy;
- HCPCS G0120 - Colorectal cancer screening; barium enema; as an alternative to HCPCS G0105, screening colonoscopy.

Effective for services furnished on or after July 1, 2001, the following codes are added for colorectal cancer screening services:

- HCPCS G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk.
- HCPCS G0122 - Colorectal cancer screening; barium enema (non-covered).

Effective for services furnished on or after January 1, 2004, the following code is added for colorectal cancer screening services as an alternative to CPT 82270* (HCPCS G0107*):

- HCPCS G0328 - Colorectal cancer screening; immunoassay, fecal-occult blood test, 1-3 simultaneous determinations.

Effective for services furnished on or after October 9, 2014, the following code is added for colorectal cancer screening services:

- HCPCS G0464 - Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3). Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528.

Effective for services furnished on or after January 19, 2021, the following code is added for colorectal cancer services:

- HCPCS G0327 - Colorectal cancer screening; blood-based biomarker Colon ca scrn;bld-bsd biomrk

Effective for claims with dates of service on or after January 1, 2023, the frequency limitations for screening colonoscopy (HCPCS codes G0105, G0121) shall not apply when the screening colonoscopy follows a positive result from a non-invasive stool-based test (HCPCS codes 82270, G0328 and 81528). This scenario is identified when the furnishing practitioner submits the screening colonoscopy claim with the KX modifier. See 42 CFR 410.37(k).

***NOTE**: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 is discontinued and replaced with CPT 82270.

G0104 – Colorectal Cancer Screening; Flexible Sigmoidoscopy

Screening flexible sigmoidoscopies (HCPCS G0104) may be paid for beneficiaries who have attained age 50, when performed by a doctor of medicine or osteopathy at the frequencies noted below.

For claims with dates of service on or after January 1, 2002, A/B MACs (A) and (B) pay for screening flexible sigmoidoscopies (HCPCS G0104) for beneficiaries who have attained age 50 when these services were performed by a doctor of medicine or osteopathy, or by a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) (as defined in §1861(aa)(5) of the Social Security Act (the Act) and in the Code of Federal Regulations (CFR) at 42 CFR 410.74, 410.75, and 410.76) at the frequencies noted above. For claims with dates of service prior to January 1, 2002, Medicare Administrative Contractors (MACs) pay for these services under the conditions noted only when a doctor of medicine or osteopathy performs them.

For services furnished from January 1, 1998, through June 30, 2001, inclusive:

- Once every 48 months (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed).

For services furnished on or after July 1, 2001:

- Once every 48 months as calculated above **unless** the beneficiary does not meet the criteria for high risk of developing colorectal cancer (refer to §60.3 of this chapter) **and** he/she has had a screening colonoscopy (HCPCS G0121) within the preceding 10 years.

If such a beneficiary has had a screening colonoscopy within the preceding 10 years, then he or she can have covered a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that he/she received the screening colonoscopy (HCPCS G0121).

Effective for claims with dates of service on or after January 1, 2023, the minimum age for screening flexible sigmoidoscopy is reduced to 45 years and older.

NOTE: If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth; the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal along with modifier -PT should be billed and paid rather than HCPCS G0104.

HCPCS G0105 – Colorectal Cancer; Colonoscopy on Individual at High Risk

Screening colonoscopies (HCPCS code G0105) may be paid when performed by a doctor of medicine or osteopathy at a frequency of once every 24 months for beneficiaries at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered HCPCS G0105 screening colonoscopy was performed). Refer to §60.3 of this chapter for the criteria to use in determining whether or not an individual is at high risk for developing colorectal cancer.

NOTE: If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal along with modifier -PT should be billed and paid rather than HCPCS G0105.

A. Colonoscopy Cannot be Completed Because of Extenuating Circumstances

1. A/B MACs (A)

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy as long as the coverage conditions are met for the incomplete procedure. However, the frequency standards associated with screening colonoscopies will not be applied by the Common Working File (CWF). When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met, and the frequency standards will be applied by CWF. This policy is applied to both screening and diagnostic colonoscopies. When submitting a facility claim for the interrupted colonoscopy, providers are to suffix the colonoscopy.

Use of HCPCS codes with a modifier of -73 or -74 is appropriate to indicate that the procedure was interrupted. Payment for covered incomplete screening colonoscopies shall be consistent with payment methodologies currently in place for complete screening colonoscopies, including those contained in 42 CFR 419.44(b). In situations where a CAH has elected payment Method II for CAH patients, payment shall be consistent with payment methodologies currently in place as outlined in chapter 3 of this manual. As such, instruct CAHs that elect Method II payment to use modifier -53 to identify an incomplete screening colonoscopy (physician professional service(s) billed in revenue code 096X, 097X, and/or 098X). Such CAHs will also bill the technical or

facility component of the interrupted colonoscopy in revenue code 075X (or other appropriate revenue code) using the -73 or -74 modifier as appropriate.

Note that Medicare would expect the provider to maintain adequate information in the patient's medical record in case it is needed by the A/B MAC (A) to document the incomplete procedure.

2. A/B MACs (B)

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances (see chapter 12, section 30.1), Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes. The MPFS database has specific values for codes 44388-53, 45378-53, G0105-53 and G0121-53. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met. This policy is applied to both screening and diagnostic colonoscopies. When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with a modifier of -53 to indicate that the procedure was interrupted. When submitting a claim for the facility fee associated with this procedure, ASCs) are to suffix the colonoscopy code with modifier -73 or -74 as appropriate. Payment for covered screening colonoscopies, including that for the associated ASC facility fee when applicable, shall be consistent with payment for diagnostic colonoscopies, whether the procedure is complete or incomplete.

Note that Medicare would expect the provider to maintain adequate information in the patient's medical record in case it is needed by the A/B MAC (B) to document the incomplete procedure.

HCPCS G0106 – Colorectal Cancer Screening; Barium Enema; as an Alternative to HCPCS G0104, Screening Sigmoidoscopy

Screening barium enema examinations may be paid as an alternative to a screening sigmoidoscopy (HCPCS G0104). The same frequency parameters for screening sigmoidoscopies (see those codes above) apply.

In the case of an individual aged 50 or over, payment may be made for a screening barium enema examination (HCPCS G0106) performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed. For example, the beneficiary received a screening barium enema examination as an alternative to a screening flexible sigmoidoscopy in January 1999. Start count beginning February 1999. The beneficiary is eligible for another screening barium enema in January 2003.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening flexible sigmoidoscopy for the same individual. The screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; Barium Enema; as an Alternative to Screening Sigmoidoscopy is reduced to 45 years and older.

CPT 82270* (HCPCS G0107*) **– Colorectal Cancer Screening; FOBT, 1-3 Simultaneous Determinations**

Effective for services furnished on or after January 1, 1998, screening FOBT (code 82270* (HCPCS G0107*) may be paid for beneficiaries who have attained age 50, and at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed). This screening FOBT means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. This screening requires a written order from the beneficiary's attending physician, or effective for dates of service on or after January 27, 2014, the beneficiary's attending physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.)

Effective for services furnished on or after January 1, 2004, payment may be made for an immunoassay-based FOBT (HCPCS G0328, described below) as an alternative to the guaiac-based FOBT, CPT 82270* (HCPCS G0107*). Medicare will pay for only one covered FOBT per year, either CPT 82270* (HCPCS G0107*) or HCPCS G0328, but not both.

***NOTE**: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 is discontinued and replaced with CPT 82270.

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; FOBT, 1-3 Simultaneous Determinations is reduced to 45 years and older.

HCPCS G0328 – Colorectal Cancer Screening; Immunoassay, FOBT, 1-3 Simultaneous Determinations

Effective for services furnished on or after January 1, 2004, screening FOBT, (HCPCS G0328) may be paid as an alternative to CPT 82270* (HCPCS G0107*) for beneficiaries who have attained age 50. Medicare will pay for a covered FOBT (either CPT 82270* (HCPCS G0107*) or HCPCS G0328, but not both) at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed).

Screening FOBT, immunoassay, includes the use of a spatula to collect the appropriate number of samples or the use of a special brush for the collection of samples, as determined by the individual manufacturer's instructions. This screening requires a written order from the beneficiary's attending physician, or effective for claims with dates of service on or after January 27, 2014, the beneficiary's attending PA, NP, or CNS. (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.)

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; Immunoassay, FOBT, 1-3 Simultaneous Determinations is reduced to 45 years and older.

HCPCS G0120 – Colorectal Cancer Screening; Barium Enema; as an Alternative to HCPCS G0105, Screening Colonoscopy

Screening barium enema examinations may be paid as an alternative to a screening colonoscopy (HCPCS G0105) examination. The same frequency parameters for screening colonoscopies (see those codes above) apply.

In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination (HCPCS G0120) performed after at least 23 months have passed following the month in which the last screening barium enema or the last screening colonoscopy was performed. For example, a beneficiary at high risk for developing colorectal cancer received a screening barium enema examination (HCPCS G0120) as an alternative to a screening colonoscopy (HCPCS G0105) in January 2000. Start counts beginning February 2000. The beneficiary is eligible for another screening barium enema examination (HCPCS G0120) in January 2002.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening colonoscopy, for the same individual. The screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening; Barium Enema; as an Alternative to Screening Colonoscopy is reduced to 45 years and older.

HCPCS G0121 – Colorectal Cancer Screening; Colonoscopy on Individual Not Meeting Criteria for High Risk - Applicable On and After July 1, 2001

Effective for services furnished on or after July 1, 2001, screening colonoscopies (HCPCS G0121) performed on individuals not meeting the criteria for being at high risk for developing colorectal cancer (refer to §60.3 of this chapter) may be paid under the following conditions:

- At a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered HCPCS G0121 screening colonoscopy was performed.)

- If the individual would otherwise qualify to have covered a HCPCS G0121 screening colonoscopy based on the above **but** has had a covered screening flexible sigmoidoscopy (HCPCS G0104), then he or she may have covered a HCPCS G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered HCPCS G0104 flexible sigmoidoscopy was performed.

NOTE: If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal along with modifier -PT should be billed and paid rather than HCPCS G0121.

HCPCS G0464 (Replaced with CPT 81528) - Multitarget sDNA Colorectal Cancer Screening Test - Cologuard™

Effective for dates of service on or after October 9, 2014, colorectal cancer screening using the Cologuard™ multi-target sDNA test (G0464/81528) is covered once every 3 years for Medicare beneficiaries that meet all of the following criteria:

- Ages 50 to 85 years,
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac FOBT or fecal immunochemical test), and,
- At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or, inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancer adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

Effective for claims with dates of service on or after October 9, 2014, providers shall report at least ONE of the following diagnosis codes when submitting claims for the Cologuard™ multi-target sDNA test:

Z12.11 Encounter for screening for malignant neoplasm of colon, OR, Z12.12

Encounter for screening for malignant neoplasm of rectum

NOTE: Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Multitarget sDNA Colorectal Cancer Screening Test - Cologuard™ is reduced to 45 years and older.

HCPCS G0327- Colorectal Cancer Screening - Blood-based Biomarker Tests

Blood-based DNA testing detects molecular markers of altered DNA that are contained in the cells shed into the lumen of the large bowel by colorectal cancer and pre-malignant colorectal epithelial neoplasia.

Effective for dates of service on or after January 19, 2021, a blood-based biomarker test is covered as an appropriate colorectal cancer screening test once every 3 years for Medicare beneficiaries when performed in a CLIA-certified laboratory, when ordered by a treating physician and when all of the following requirements are met:

The patient is:

- age 50-85 years, and,

- asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac FOBT or fecal immunochemical test), and,
- at average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer , or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

The blood-based biomarker screening test must have all of the following:

- FDA market authorization with an indication for colorectal cancer screening; and,

- proven test performance characteristics for a blood-based screening test with both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in the detection of colorectal cancer compared to the recognized standard (accepted as colonoscopy at this time), as minimal threshold levels, based on the pivotal studies included in the FDA labeling.

Effective for claims with dates of service on or after January 19, 2021, providers shall report at least ONE of the following diagnosis codes when submitting claims for the Blood-based Biomarker test HCPCS G0327:

Z12.11 Encounter for screening for malignant neoplasm of colon, OR, Z12.12

Encounter for screening for malignant neoplasm of rectum

Effective for claims with dates of service on or after January 1, 2023, the minimum age for Colorectal Cancer Screening - Blood-based Biomarker Tests is reduced to 45 years and older.

HCPCS G0122 – Colorectal Cancer Screening; Barium Enema

The code is not covered by Medicare.

60.2.1 - Common Working Files (CWF) Edits

(Rev. 10818; Issued: 05-20-21; Effective: 01-09-21; Implementation: 10-04-21)

Effective for dates of service January 1, 1998, and later, CWF will edit all colorectal screening claims for age and frequency standards. The CWF will also edit A/B MAC (A) claims for valid procedure codes (HCPCS G0104, G0105, G0106, CPT 82270* (HCPCS G0107*), G0120, G0121, G0122, G0328, G0327, and CPT 81528 ** (HCPCS G0464**). The CWF currently edits for valid HCPCS codes for A/B/MACs (B). (See §60.6 of this chapter for TOBs.)

***NOTE**: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 is discontinued and replaced with CPT 82270.

** Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528.

60.2.2 - Ambulatory Surgical Center (ASC) Facility Fee

(Rev. 10818; Issued: 05-20-21; Effective: 01-09-21; Implementation: 10-04-21)

CPT code 45378, which is used to code a diagnostic colonoscopy, is on the list of procedures approved by Medicare for payment of an ambulatory surgical center facility under section 1833 of the Act. CPT code 45378 is currently assigned to ASC payment group 2. Code G0105, colorectal cancer; colonoscopy on individuals at high risk, was added to the ASC list effective for services

furnished on or after January 1, 1998. Code G0121, colorectal cancer; colonoscopy on individual not meeting criteria for high risk, was added to the ASC list effective for services furnished on or after July 1, 2001. Codes G0105 and G0121 are assigned to ASC payment group 2. The ASC facility service is the same whether the procedure is a screening or a diagnostic colonoscopy. If during the course of the screening colonoscopy performed at an ASC, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed rather than code G0105. Effective for services performed on or after January 1, 2007, a 25% coinsurance payment will apply for the colorectal cancer services (G0105 and G0121).

60.3 - Determining High Risk for Developing Colorectal Cancer

(Rev. 13025, Issued: 12-23-24; Effective: 10-01-24; Implementation: 03-20-25)

A. Characteristics of the High-Risk Individual

An individual at high risk for developing colorectal cancer has one or more of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp.
- A family history of familial adenomatous polyposis.
- A family history of hereditary nonpolyposis colorectal cancer.
- A personal history of adenomatous polyps.
- A personal history of colorectal cancer; or
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

B. Partial List of ICD-10-CM Codes Indicating High Risk

Listed below are some examples of diagnoses that meet the high-risk criteria for colorectal cancer. This is not an all-inclusive list. There may be more instances of conditions, which may be coded and could be considered high risk at the medical directors' discretion.

Partial List of diagnosis codes indicating high risk: only applicable to G0105 and G0120 (high risk colorectal cancer screening)

C18.0	Malignant neoplasm of cecum
C18.2	Malignant neoplasm of ascending colon
C18.3	Malignant neoplasm of hepatic flexure
C18.4	Malignant neoplasm of transverse colon
C18.5	Malignant neoplasm of splenic flexure

C18.6	Malignant neoplasm of descending colon
C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21.0	Malignant neoplasm of anus, unspecified
C21.1	Malignant neoplasm of anal canal
C21.2	Malignant neoplasm of cloacogenic zone
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C49.A	Gastrointestinal stromal tumor of small intestine
C49.A	Gastrointestinal stromal tumor of large intestine
C49.A5	Gastrointestinal stromal tumor of rectum
C78.5	Secondary malignant neoplasm of large intestine and rectum
C7A.02	Malignant carcinoid tumor of the cecum
C7A.022	Malignant carcinoid tumor of the ascending colon
C7A.023	Malignant carcinoid tumor of the transverse colon
C7A.024	Malignant carcinoid tumor of the descending colon
C7A.025	Malignant carcinoid tumor of the sigmoid colon
C7A.026	Malignant carcinoid tumor of the rectum
D01.0	Carcinoma in situ of colon
D01.1	Carcinoma in situ of rectosigmoid junction
D01.2	Carcinoma in situ of rectum
D01.3	Carcinoma in situ of anus and anal canal
D12.0	Benign neoplasm of cecum
D12.2	Benign neoplasm of ascending colon
D12.3	Benign neoplasm of transverse colon
D12.4	Benign neoplasm of descending colon
D12.5	Benign neoplasm of sigmoid colon
D12.7	Benign neoplasm of rectosigmoid junction
D12.8	Benign neoplasm of rectum
D12.9	Benign neoplasm of anus and anal canal
D37.4	Neoplasm of uncertain behavior of colon
D37.5	Neoplasm of uncertain behavior of rectum
D37.9	Neoplasm of uncertain behavior of digestive organ, unspecified
D3A.021	Benign carcinoid tumor of the cecum
D3A.022	Benign carcinoid tumor of the ascending colon
D3A.023	Benign carcinoid tumor of the transverse colon
D3A.024	Benign carcinoid tumor of the descending colon
D3A.025	Benign carcinoid tumor of the sigmoid colon
D3A.026	Benign carcinoid tumor of the rectum
D3A.029	Benign carcinoid tumor of the large intestine, unspecified portion
K50.00	Crohn's disease of small intestine without complications
K50.011	Crohn's disease of small intestine with rectal bleeding
K50.012	Crohn's disease of small intestine with intestinal obstruction
K50.013	Crohn's disease of small intestine with fistula
K50.014	Crohn's disease of small intestine with abscess
K50.018	Crohn's disease of small intestine with other complication

K50.019	Crohn's disease of small intestine with unspecified complications
K50.10	Crohn's disease of large intestine without complications
K50.111	Crohn's disease of large intestine with rectal bleeding
K50.112	Crohn's disease of large intestine with intestinal obstruction
K50.113	Crohn's disease of large intestine with fistula
K50.114	Crohn's disease of large intestine with abscess
K50.118	Crohn's disease of large intestine with other complication
K50.119	Crohn's disease of large intestine with unspecified complications
K50.80	Crohn's disease of both small and large intestine without complications
K50.811	Crohn's disease of both small and large intestine with rectal bleeding
K50.812	Crohn's disease of both small and large intestine with intestinal obstruction
K50.813	Crohn's disease of both small and large intestine with fistula
K50.814	Crohn's disease of both small and large intestine with abscess
K50.818	Crohn's disease of both small and large intestine with other complication
K50.819	Crohn's disease of both small and large intestine with unspecified complications
K50.90	Crohn's disease, unspecified, without complications
K50.911	Crohn's disease, unspecified, with rectal bleeding
K50.912	Crohn's disease, unspecified, with intestinal obstruction
K50.913	Crohn's disease, unspecified, with fistula
K50.914	Crohn's disease, unspecified, with abscess
K50.918	Crohn's disease, unspecified, with other complication
K50.919	Crohn's disease, unspecified, with unspecified complications
K51.00	Ulcerative (chronic) pancolitis without complications
K51.011	Ulcerative (chronic) pancolitis with rectal bleeding
K51.012	Ulcerative (chronic) pancolitis with intestinal obstruction
K51.013	Ulcerative (chronic) pancolitis with fistula
K51.014	Ulcerative (chronic) pancolitis with abscess
K51.018	Ulcerative (chronic) pancolitis with other complication
K51.019	Ulcerative (chronic) pancolitis with unspecified complications
K51.20	Ulcerative (chronic) proctitis without complications
K51.211	Ulcerative (chronic) proctitis with rectal bleeding
K51.212	Ulcerative (chronic) proctitis with intestinal obstruction
K51.213	Ulcerative (chronic) proctitis with fistula
K51.214	Ulcerative (chronic) proctitis with abscess
K51.218	Ulcerative (chronic) proctitis with other complication
K51.219	Ulcerative (chronic) proctitis with unspecified complications
K51.30	Ulcerative (chronic) rectosigmoiditis without complications
K51.311	Ulcerative (chronic) rectosigmoiditis with rectal bleeding
K51.312	Ulcerative (chronic) rectosigmoiditis with intestinal obstruction
K51.313	Ulcerative (chronic) rectosigmoiditis with fistula
K51.314	Ulcerative (chronic) rectosigmoiditis with abscess
K51.318	Ulcerative (chronic) rectosigmoiditis with other complication
K51.319	Ulcerative (chronic) rectosigmoiditis with unspecified complications
K51.40	Inflammatory polyps of colon without complications
K51.411	Inflammatory polyps of colon with rectal bleeding
K51.412	Inflammatory polyps of colon with intestinal obstruction

K51.413	Inflammatory polyps of colon with fistula
K51.414	Inflammatory polyps of colon with abscess
K51.418	Inflammatory polyps of colon with other complication
K51.419	Inflammatory polyps of colon with unspecified complications
K51.50	Left sided colitis without complications
K51.511	Left sided colitis with rectal bleeding
K51.512	Left sided colitis with intestinal obstruction
K51.513	Left sided colitis with fistula
K51.514	Left sided colitis with abscess
K51.518	Left sided colitis with other complication
K51.519	Left sided colitis with unspecified complications
K51.80	Other ulcerative colitis without complications
K51.811	Other ulcerative colitis with rectal bleeding
K51.812	Other ulcerative colitis with intestinal obstruction
K51.813	Other ulcerative colitis with fistula
K51.814	Other ulcerative colitis with abscess
K51.818	Other ulcerative colitis with other complication
K51.819	Other ulcerative colitis with unspecified complications
K51.90	Ulcerative colitis, unspecified, without complications
K51.911	Ulcerative colitis, unspecified with rectal bleeding
K51.912	Ulcerative colitis, unspecified with intestinal obstruction
K51.913	Ulcerative colitis, unspecified with fistula
K51.914	Ulcerative colitis, unspecified with abscess
K51.918	Ulcerative colitis, unspecified with other complication
K51.919	Ulcerative colitis, unspecified with unspecified complications
K52.1	Toxic gastroenteritis and colitis
K52.89	Other specified non-infective gastroenteritis and colitis
K52.9	Non-infective gastroenteritis and colitis, unspecified
K57.20	Diverticulitis of large intestine with perforation and abscess without bleeding
K57.21	Diverticulitis of large intestine with perforation and abscess with bleeding
K57.30	Diverticulosis of large intestine without perforation or abscess without bleeding
K57.31	Diverticulosis of large intestine without perforation or abscess with bleeding
K57.32	Diverticulitis of large intestine without perforation or abscess without bleeding
K57.33	Diverticulitis of large intestine without perforation or abscess with bleeding
K57.40	Diverticulitis of both small and large intestine with perforation and abscess without bleeding
K57.41	Diverticulitis of both small and large intestine with perforation and abscess with bleeding
K57.50	Diverticulosis of both small and large intestine without perforation or abscess without bleeding
K57.51	Diverticulosis of both small and large intestine without perforation or abscess with bleeding
K57.52	Diverticulitis of both small and large intestine without perforation or abscess without bleeding
K57.53	Diverticulitis of both small and large intestine without perforation or abscess with bleeding
K57.80	Diverticulitis of intestine, part unspecified, with perforation and abscess without

	bleeding
K57.81	Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding
K57.90	Diverticulosis of intestine, part unspecified, without perforation or abscess without bleeding
K57.91	Diverticulosis of intestine, part unspecified, without perforation or abscess with bleeding
K57.92	Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding
K57.93	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding
K62.0	Anal polyp
K62.1	Rectal polyp
K62.6	Ulcer of anus and rectum
K63.3	Ulcer of intestine
K63.5	Polyp of colon
Z12.10	Encounter for screening for malignant neoplasm of intestinal tract, unspecified
Z12.11	Encounter for screening for malignant neoplasm of colon
Z12.12	Encounter for screening for malignant neoplasm of rectum
Z15.09	Genetic susceptibility to other malignant neoplasm
Z80.0	Family history of malignant neoplasm of digestive organs
Z83.710	Family history of adenomatous and serrated polyps
Z83.711	Family history of hyperplastic colon polyps
Z83.718	Other family history of colon polyps
Z83.719	Family history of colon polyps, unspecified
Z83.72	Family history of familial adenomatous polyposis effective October 1 ,2024
Z85.038	Personal history of other malignant neoplasm of large intestine
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
Z86.004	Personal history of in-situ neoplasm of other and unspecified digestive organs
Z86.010	Personal history of colonic polyps end date September 30, 2024
Z86.0100	Personal history of colon polyps, unspecified effective October 1 ,2024
Z86.0101	Personal history of adenomatous and serrated colon polyps effective October 1, 2024
Z86.0102	Personal history of hyperplastic colon polyps effective October 1 ,2024
Z86.0109	Personal history of other colon polyps October 1 ,2024

Applicable to G0464/81528: colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., kras, ndrg4 and bmp3), as well as G0327: colorectal cancer screening; blood-based biomarker - only 1 diagnosis required

Z12.12 Encounter for screening for malignant neoplasm of rectum
Z12.11 Encounter for screening for malignant neoplasm of colon

60.4 - Determining Frequency Standards

(Rev. 3436, Issued: 12-30-15, Effective: 10-09-14, Implementation: 09-08-15 for non-shared MAC edits; 01-04-16 - For all shared system changes.)

To determine the 11-, 23-, 35-, 47-, and 119-month periods, start counts beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received an FOBT in January 2000. Start count beginning with February 2000. The beneficiary is eligible to receive another blood test in January 2001 (the month after 11 full months have passed).

60.5 - Noncovered Services

(Rev. 10818; Issued: 05-20-21; Effective: 01-09-21; Implementation: 10-04-21)

The following non-covered HCPCS codes are used to allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes for the dates of service indicated:

A. From January 1, 1998, through June 30, 2001, Inclusive

Code G0121 (colorectal cancer; colonoscopy on an individual not meeting criteria for high risk) should be used when this procedure is performed on a beneficiary who does **not** meet the criteria for high risk. This service should be denied as non-covered because it fails to meet the requirements of the benefit for these dates of service. The beneficiary is liable for payment. Note that this code is a covered service for dates of service on or after July 1, 2001.

B. On or After January 1, 1998

Code G0122 (colorectal cancer; barium enema) should be used when a screening barium enema is performed **not** as an alternative to either a screening colonoscopy (code G0105) or a screening flexible sigmoidoscopy (code G0104). This service should be denied as non-covered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

60.6 - Billing Requirements for Claims Submitted to A/B MACs (A)

(Rev. 10818; Issued: 05-20-21; Effective: 01-09-21; Implementation: 10-04-21)

Follow the general bill review instructions in chapter 25. Hospitals use the ASC X12 837 institutional claim format to bill the A/B MAC (A) or the hardcopy Form CMS-1450 (UB-04). Hospitals bill revenue codes and HCPCS codes as follows:

Screening Tests/Procedures	Revenue Codes	HCPCS Codes	TOBs
FOBT	030X	82270*** (G0107***), G0328	12X, 13X, 14X**, 22X, 23X, 83X, 85X

Screening Tests/Procedures	Revenue Codes	HCPCS Codes	TOBs
Barium enema	032X	G0106, G0120, G0122	12X, 13X, 22X, 23X, 85X****
Flexible Sigmoidoscopy	*	G0104	12X, 13X, 22X, 23X, 85X****
Colonoscopy-high risk	*	G0105, G0121	12X, 13X, 22X, 23X, 85X****
Multitarget sDNA - Cologuard™	030X	(G0464*****), 81528*****	13X, 14X** 85X
Blood-based Biomarker	030X	(G0327)	13X, 14X** 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, HCPCS G0107, was discontinued and replaced with CPT 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.

***** Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528

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 TOB 12X using the discharge date of the hospital stay to avoid editing in CWF as a result of the hospital bundling rules.

60.7 - Medicare Summary Notice (MSN) Messages

(Rev. 12299; Issued:10-12-23; Effective:01-01-23; Implementation:11-13-23)

The following Medicare Summary Notice (MSN) messages are used (See Chapter 21 for the Spanish versions of these messages):

A. If a claim for a screening FOBT, a screening flexible sigmoidoscopy, or a barium enema is being denied because of the age of the beneficiary, use:

18.29 - This service is not covered for people under 45 years of age.

Spanish Version- “Este servicio no está cubierto para las personas menores de 45 años.”
B. If the claim for a screening FOBT, a screening colonoscopy, a screening flexible sigmoidoscopy, or a barium enema is being denied because the time period between the same test or procedure has not passed, use:
18.14 - Service is being denied because it has not been (12, 24, 48, 120) months since your last (test/procedure) of this kind.

C. If the claim is being denied for a screening colonoscopy or a barium enema because the beneficiary is not at a high risk, use:
18.15 - Medicare covers this procedure only for people considered to be at a high risk for colorectal cancer.
D. If the claim is being denied because payment has already been made for a screening FOBT (CPT 82270* (HCPCS G0107*) or HCPCS G0328), flexible sigmoidoscopy (HCPCS G0104), screening colonoscopy (HCPCS G0105), or a screening barium enema (HCPCS G0106 or G0120), use:
18.16 - This service is denied because payment has already been made for a similar procedure within a set timeframe.

NOTE: MSN message 18.16 should only be used when a certain screening procedure is performed as an alternative to another screening procedure. For example: If the claims history indicates a payment has been made for HCPCS G0120 and an incoming claim is submitted for HCPCS G0105 within 24 months, the incoming claim should be denied.
E. If the claim is being denied for a non-covered screening procedure code such as HCPCS G0122, use:

16.10 - Medicare does not pay for this item or service.

If an invalid procedure code is reported, the contractor will return the claim as unprocessable to the provider under current procedures.

***NOTE**: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 is discontinued and replaced with CPT 82270.
F. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) when furnished more than once in a 3-year period [at least 2 years and 11 full months (35 months total) must elapse from the date of the last screening], use:

15.19: “We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.

15.20 - The following policies NCD 210.3 were used when we made this decision

Spanish Version – “Las siguientes políticas NCD210.3 fueron utilizadas cuando se tomó esta decisión”

NOTE: Due to system requirement, the Fiscal Intermediary Standard System (FISS) has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.
G. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) because the beneficiary is not between the ages of 45 and 85, use:

15.19 - "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.

15.20 - The following policies NCD 210.3 were used when we made this decision.

Spanish Version – "Las siguientes políticas NCD 210.3 fueron utilizadas cuando se tomó esta decision."

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.
H. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) because the claim does not contain all of the ICD-10 diagnosis codes required, use:

15.19 - "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.

15.20 - The following policies 210.3 were used when we made this decision

Spanish Version – "Las siguientes políticas NCD210.3 fueron utilizadas cuando se tomó esta decisión"

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

I. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) on institutional claims when submitted on a TOB other than 13X, 14X, and 85X, use:

21.25 - This service was denied because Medicare only covers this service in certain settings.

Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

60.8 - Remittance Advice Codes

(Rev. 12299; Issued:10-12-23; Effective:01-01-23; Implementation:11-13-23)

All messages refer to ANSI X12N 835 coding.

A. If the claim for a screening FOBT, a screening flexible sigmoidoscopy, or a screening barium enema is being denied because the patient is less than 45 years of age, use:

Claim Adjustment Reason Code (CARC) 6 "The procedure/revenue code is inconsistent with the patient's age," at the line level; and, Remittance Advice Remark Code (RARC) N129 "Not eligible due to patient's age"

B. If the claim for a screening FOBT, a screening colonoscopy, a screening flexible sigmoidoscopy, or a screening barium enema is being denied because the time period between the test/procedure has not passed, use:

- CARC 119 "Benefit maximum for this time period or occurrence has been reached" at the line level.

C. If the claim is being denied for a screening colonoscopy (HCPCS G0105) or a screening barium enema (HCPCS G0120) because the patient is not at a high risk, use:

- CARC 46 "This (these) service(s) is (are) not covered" at the line level; and,
- RARC M83 "Service is not covered unless the patient is classified as a high risk." at the line level.

D. If the service is being denied because payment has already been made for a similar procedure within the set time frame, use:

- CARC 18, "Duplicate claim/service" at the line level; and,

- RARC M86 "Service is denied because payment already made for similar procedure within a set timeframe." at the line level.

E. If the claim is being denied for a non-covered screening procedure such as HCPCS G0122, use:

CARC 49, "These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam."

F. If the claim is being denied because the code is invalid, use the following at the line level:

- CARC B18 "Payment denied because this procedure code/modifier was invalid on the date of service or claim submission."

G. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) when furnished more than once in a 3-year period [at least 2 years and 11 full months (35 months total) must elapse from the date of the last screening], use:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."

- RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

H. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) when beneficiary is not between the ages 45-85, use:

- CARC 6: "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

- RARC N129: "Not eligible due to the patient's age."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

I. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) when the claim does not contain ICD-10 diagnosis codes Z12.12 OR Z12.11), use:

- CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

J. If denying claims for Cologuard™ multi-target sDNA screening test (HCPCS G0464 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528) or Blood-based Biomarker test (HCPCS G0327) when claims are submitted on a TOB other than 13X, 14X, or 85X, use:

- CARC 170: "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N95 – "This provider type/provider specialty may not bill this service."

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

70 - Glaucoma Screening Services
(Rev. 1, 10-01-03)

B3-4184

Conditions of Medicare Part B coverage for glaucoma screening are located in the Medicare Benefit Policy Manual, Chapter 15.

70.1 - Claims Submission Requirements and Applicable HCPCS Codes
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

70.1.1 - HCPCS and Diagnosis Coding
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

The following HCPCS codes should be reported when billing for screening glaucoma services:

G0117 - Glaucoma screening for high-risk patients furnished by an optometrist (physician for A/B MAC (B)) or ophthalmologist.

G0118 - Glaucoma screening for high-risk patients furnished under the direct supervision of an optometrist (physician for A/B MAC (B) or ophthalmologist.

The A/B MAC (B) claims type of service for the above G codes is: TOS Q.

Glaucoma screening claims should be billed using screening ("V") code V80.1 (Special Screening for Neurological, Eye, and Ear Diseases, Glaucoma), or if ICD-10-CM is applicable, diagnosis code Z13.5 (encounter for screening for eye and ear disorders). Claims submitted without a screening diagnosis code may be returned to the provider as unprocessable (refer to chapter 1 of this manual for more information about incomplete or invalid claims).

70.1.1.1 - Additional Coding Applicable to Claims Submitted to A/B MACs (A)
(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Type of Bill

The applicable A/B MAC (A) claim bill types for screening glaucoma services are 13X, 22X, 23X, 71X, 73X, 75X, and 85X. (See instructions below for rural health clinics (RHCs) and federally qualified health centers (FQHCs).)

B. Revenue Coding

The following revenue codes should be reported when billing for screening glaucoma services: Comprehensive outpatient rehabilitation facilities (CORFs), critical access hospitals (CAHs), and skilled nursing facilities (SNFs) bill for this service under revenue code 0770. CAHs electing the optional method of payment for outpatient services also report this service under revenue codes 096X, 097X, or 098X. Hospital outpatient departments bill for this service under any valid/appropriate revenue code. They are not required to report revenue code 0770. (See instructions below for RHCs and FQHCs.)

70.1.1.2 - Special Billing Instructions for RHCs and FQHCs
(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Screening glaucoma services are considered RHC/FQHC services. For claims with dates of service before April 1, 2005, RHCs and FQHCs bill the A/B MAC (A) under bill type 71X or 73X along with revenue code 0770 and HCPCS codes G0117 or G0118 and RHC/FQHC revenue code 0520 or 0521 to report the related visit. Reporting of revenue code 0770 and HCPCS codes G0117 and G0118 in addition to revenue code 0520 or 0521 is required for this service in order for CWF to perform frequency editing. Payment should not be made for a screening glaucoma service unless the claim also contains a visit code for the service. A/B MACs (A) must edit to assure payment is not made for revenue code 0770. The claim must also contain a visit revenue code (0520 or 0521). Payment is made for the screening glaucoma service under the all-inclusive rate for the line item reporting revenue code 0520 or 0521. No payment is made on the line item reporting revenue code 0770.

Screening glaucoma services furnished within an RHC/FQHC by a physician or nonphysician are considered RHC/FQHC services. For claims with dates of service on or after April 1, 2005, RHCs and FQHCs bill the A/B MAC (A) under bill type 71X or 73X for the service. Payment is made under the all-inclusive rate. Additional revenue and HCPCS coding is no longer required for this service when RHCs/FQHCs are billing for the service. Use revenue code 0520 or 0521, as appropriate.

70.1.2 - Edits
(Rev. 1, 10-01-03)

B3-4184.4, A-01-132 (CR 1914), B3-4184.5

A. Common Working File Edits

Effective January 1, 2002, CWF edits glaucoma screening claims for frequency and valid HCPCS codes for dates of service January 1, 2002, and later.

B. Claims Edits

Nationwide claims processing edits for pre or post payment review of claim(s) for glaucoma screening are not required at this time. A/B MACs (A) and (B) monitor claims to assure that they are paid only for covered individuals and perform medical review as appropriate. Local medical review policies and edits may be developed for such claims.

70.2 - Payment Methodology
(Rev. 1, 10-01-03)

B3-4184.7, A-01-132 (CR 1914), A-01-105(CR 1783), B-01-46 (CR 1717)

A/B MACs (B) pay for glaucoma screening based on the Medicare Physician Fee Schedule. Deductible and coinsurance apply. Claims from physicians or other providers where assignment was not taken are subject to the

Medicare limiting charge, which means they cannot charge the beneficiary more than 115 percent of the allowed amount.

A/B MAC (A) pay the facility expense as follows:

- Independent and provider-based RHC/free standing and provider-based FQHC receive payment under the all-inclusive rate for the screening glaucoma service based on the visit furnished to the RHC/FQHC patient;
- CAHs receive payment on a reasonable cost basis unless the CAH has elected the optional method of payment for outpatient services in which case, procedures outlined in Chapter 4 should be followed;
- CORFs receive payment under the Medicare Physician Fee Schedule;
- Hospital outpatient departments receive payment under the outpatient prospective payment system (OPPS);
- Hospital inpatient Part B services are paid under OPPS;
- SNF outpatient services are paid under the Medicare physician fee schedule (MPFS); and
- SNF inpatient Part B services are paid under MPFS.

Deductible and coinsurance apply.

70.3 - Determining the 11-Month Period
(Rev. 1, 10-01-03)

A-01-132 (CR 1914), B3-4184.3

Once a beneficiary has received a covered glaucoma screening procedure, the beneficiary may receive another procedure after 11 full months have passed. To determine the 11-month period, start counts beginning with the month after the month in which the previous covered screening procedure was performed.

70.4 - Remittance Advice Notices
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

Appropriate remittance advice(s) must be used by A/B MACs (A) and (B) when denying payment for glaucoma screening. The following messages are used where applicable:

- If the services were furnished before January 1, 2002, use existing ASC X12 835 remittance advice claim adjustment reason code 26 “Expenses incurred prior to coverage” at the line level.
- If the claim for glaucoma screening is being denied because the minimum time period has not elapsed since the performance of the same Medicare covered procedure, use existing ASC X12 835 claim adjustment reason code 119 “Benefit maximum for this time period has been reached” at the line level.
- If the service is being denied because the individual is not an African-American age 50 or over, use existing remittance advice claim adjustment reason code 6, “The procedure code is inconsistent with the patient’s age,” and existing remark codes M83, “Service not covered unless the patient is classified as at high risk,” and M82, “Service not covered when patient is under age 50.” Report these codes at the line level.

- If the service is being denied because the individual is not a Hispanic-American age 65 or over, use existing remittance advice claim adjustment reason code 96, “Non-covered charge,” and existing remark codes M83, “Service not covered unless the patient is classified as at high risk,” and N129, "This amount represents the dollar amount not eligible due to patient's age."

- If the service is being denied because the patient does not have diabetes mellitus, or there is no family history of glaucoma, A/B MACs (B) use existing remittance advice claim adjustment reason code B5, “Payment adjusted because coverage/program guidelines were not met or were exceeded.” The zero payment for the service will indicate the denial. In addition, report remark code M83, “Service is not covered unless the patient is classified as at high risk” at the line level.

70.5 - MSN Messages

(Rev. 895, Issued: 03-24-06; Effective: 01-01-06; Implementation: 04-03-06)

The following MSN messages where appropriate must be used.

If a claim for a screening for glaucoma is being denied because the service was performed prior to January 1, 2002, use the MSN message:

MSN Message 16.54:

> This service is not covered prior to January 1, 2002.

The Spanish version of the MSN message should read:

> Este servicio no está cubierto antes del 1 de enero de 2002.

If a claim for screening for glaucoma is being denied because the minimum time period has not elapsed since the performance of the same Medicare-covered procedure, use MSN message:

MSN Message 18.14:

> Service is being denied because it has not been [12/24/48] months since your last [test/procedure] of this kind.

The Spanish version of this MSN message should read:

> Este servicio está siendo denegado ya que no han transcurrido [12, 24, 48] meses desde el último[examen/procedimiento] de esta clase.

If a claim for a screening for glaucoma is being denied because the age-related and/or ethnic-related coverage criteria are not met, use:

MSN Message 21.21:

> This service was denied because Medicare only covers this service under certain circumstances.

The Spanish version of this MSN message should read:

> Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.

80 - Initial Preventive Physical Examination (IPPE)

(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

(**NOTE:** For billing and payment requirements for the Annual Wellness Visit, see chapter 18, section 140, of this chapter.)

Background: Sections 1861(s)(2)(w) and 1861(ww) of the Social Security Act (and implementing regulations at 42 CFR 410.16, 411.15(a)(1), and 411.15(k)(11)) authorize coverage under Part B for a one-time initial preventive physical examination (IPPE) for new Medicare beneficiaries that meet certain eligibility requirements.

Coverage: As described in implementing regulations at 42 CFR 410.16, 411.15(a)(1), and 411.15(k)(11), the IPPE may be performed by a doctor of medicine or osteopathy as defined in section 1861 (r)(1) of the Social Security Act (the Act) or by a qualified nonphysician practitioner (NPP) (physician assistant, nurse practitioner, or clinical nurse specialist), not later than 12 months after the date the individual's first coverage begins under Medicare Part B. (See section 80.3 for a list of bill types of facilities that can bill A/B MACs for this service.)

The IPPE includes:

(1) review of the individual's medical and social history with attention to modifiable risk factors for disease detection,

(2) review of the individual's potential (risk factors) for depression or other mood disorders,

(3) review of the individual's functional ability and level of safety;

(4) an examination to include measurement of the individual's height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's medical and social history;

(5) end-of-life planning, upon agreement of the individual.

(6) education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous 5 elements, and

(7) education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining appropriate screening and other preventive services, which are separately covered under Medicare Part B.

Medicare will pay for only one IPPE per beneficiary per lifetime. The Common Working File (CWF) will edit for this benefit.

The IPPE does not include other preventive services that are currently separately covered and paid under Medicare Part B. (That is: pneumococcal, influenza and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic examinations, prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, glaucoma screening, medical nutrition therapy for individuals with diabetes or renal disease, cardiovascular screening blood tests, diabetes screening tests, screening ultrasound for abdominal aortic aneurysms, an electrocardiogram, and additional preventive services covered under Medicare Part B through the Medicare national coverage determination process.)

For the physician/practitioner billing correct coding and payment policy, refer to chapter 12, section 30.6.1.1, of this manual.

80.1 - Healthcare Common Procedure Coding System (HCPCS) Coding for the IPPE
(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

The HCPCS codes listed below were developed for the IPPE benefit effective January 1, 2005, for individuals whose initial enrollment is on or after January 1, 2005.

G0344: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 6 months of Medicare enrollment

Short Descriptor: Initial Preventive Exam

G0366: Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report

Short Descriptor: EKG for initial prevent exam

G0367: tracing only, without interpretation and report, performed as a component of the initial preventive examination

Short Descriptor: EKG tracing for initial prev

G0368: interpretation and report only, performed as a component of the initial preventive examination

Short Descriptor: EKG interpret & report preve

The following new HCPCS codes were developed for the IPPE benefit effective January 1, 2009, and replaced codes G0344, G0366, G0367, and G0368 shown above beginning with dates of service on or after January 1, 2009:

G0402: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

Short Descriptor: Initial Preventive exam

G0403: Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report

Short Descriptor: EKG for initial prevent exam

G0404: Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination

Short Descriptor: EKG tracing for initial prev

G0405: Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

Short Descriptor: EKG interpret & report preve

80.2 - A/B MAC) (B) Billing Requirements
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

Effective for dates of service on and after January 1, 2005, through December 31, 2008, A/B MACs (B) shall recognize the HCPCS codes G0344, G0366, G0367, and G0368 shown above in §80.1 for an IPPE. The type of service (TOS) for each of these codes is as follows:

G0344: TOS = 1
G0366: TOS = 5
G0367: TOS = 5
G0368: TOS = 5

A/B MACs (B) shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 6 months after the date the individual's first coverage begins under Medicare Part B, but only if that coverage period begins on or after January 1, 2005.

Effective for dates of service on and after January 1, 2009, A/B MACs (B) shall recognize the HCPCS codes G0402, G0403, G0404, and G0405 shown above in §80.1 for an IPPE. The TOS for each of these codes is as follows:

G0402: TOS = 1
G0403: TOS = 5
G0404: TOS = 5
G0405: TOS = 5

Under the MIPPA of 2008, A/B MACs (B) shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 12 months after the date the individual's first coverage begins under Medicare Part B only if that coverage period begins on or after January 1, 2009.

A/B MACs (B) shall allow payment for a medically necessary Evaluation and Management (E/M) service at the same visit as the IPPE when it is clinically appropriate. Physicians and qualified nonphysician practitioners shall use CPT codes 99201-99215 to report an E/M with CPT modifier 25 to indicate that the E/M is a significant, separately identifiable service from the IPPE code reported (G0344 or G0402, whichever applies based on the date the IPPE is performed). Refer to chapter 12, §30.6.1.1, of this manual for the physician/practitioner billing correct coding and payment policy regarding E/M services.

If the EKG performed as a component of the IPPE is not performed by the primary physician or qualified NPP during the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring physician or qualified NPP needs to make sure that the performing physician or entity bills the appropriate G code for the screening EKG, and **not** a CPT code in the 93000 series. **Both the IPPE and the EKG should be billed in order for the beneficiary to receive the complete IPPE service**. Effective for dates of service on and after January 1, 2009, the screening EKG is optional and is no longer a mandated service of an IPPE if performed as a result of a referral from an IPPE.

Should the same physician or NPP need to perform an additional medically necessary EKG in the 93000 series on the same day as the IPPE, report the appropriate EKG CPT code(s) with modifier 59, indicating that the EKG is a distinct procedural service.

Physicians or qualified nonphysician practitioners shall bill the A/B MACs (B) the appropriate HCPCS codes for IPPE. The HCPCS codes for an IPPE and screening EKG are paid under the Medicare Physician Fee Schedule (MPFS). See §1.3 of this chapter for waiver of cost sharing requirements of coinsurance, copayment and deductible for furnished preventive services available in Medicare.

80.3 - A/B MAC (A) Billing Requirements

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

A/B MACs (A) will pay for IPPE or EKG only when the services are submitted on one of the following TOBs: 12X, 13X, 22X, 71X, 73X and 85X.

Type of facility and setting determines the basis of payment:

- For the IPPE or the screening EKG tracing only performed on a 12X and 13X TOB, hospital inpatient Part B and hospital outpatient, for hospitals subject to the outpatient prospective payment system (OPPS), under the OPPS. Hospitals not subject to OPPS shall be paid under current methodologies.

- For services performed on an 85X TOB, Critical Access Hospitals (CAHs), pay on reasonable cost.

- For services performed in a skilled nursing facility, TOB 22x, make payment for the technical component of the EKG based on the MPFS.

- For inpatient or outpatient services in hospitals in Maryland, make payment according to the Health Services Cost Review Commission.

- For services performed on a 12X TOB, Indian Health Services (IHS) hospitals, payment is made based on an all-inclusive ancillary per diem rate.

- For services performed on a 13X TOB, IHS hospitals, payment is made based on the all-inclusive rate (AIR).

- For services performed on an 85X TOB, IHS CAHs, payment is made based on an all-inclusive facility specific per visit rate.

All CAHs are paid for the technical or facility component of the IPPE itself. They are also paid for the technical component of the EKG, the tracing only, if the EKG is performed. Only CAHs paid under the optional method are paid for the professional component of the IPPE itself (in addition to the facility payment) for charges under revenue code 0960. If the EKG is performed, CAHs paid under the optional method may also be paid for the interpretation of the EKG (in addition to the payment for the tracing) when billed under revenue codes 0985 or 0986.

80.3.1 - Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) Special Billing Instructions

(Rev. 3669, Issued: 12-02-16, Effective: 01-01-17, Implementation: 01-03-17)

There are Initial Preventive Physical Examination (IPPE) instructions that are unique to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Refer to chapter 9, section 70.6 of this manual for a description of these instructions.

80.3.2 - Indian Health Services (IHS) Hospitals Special Billing Instructions

(Rev. 1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

For the period January 1, 2005 through December 31, 2008, the designated A/B MAC (A) pays IHS hospitals when G0344 is submitted; this includes the IPPE whether or not the screening EKG is performed at the same time. The designated A/B MAC (A) will also pay IHS hospitals for the screening EKG if HCPCS code G0367 is present. For the professional component of the EKG, the designated A/B MAC (B) shall pay the billing physician or other practitioner the established amount.

Effective January 1, 2009 the following new HCPCS codes have been developed for the IPPE benefit and replace the codes in the paragraph above: G0402 for the IPPE itself, and G0404 for the technical component (tracing only) of the EKG.

80.3.3 - Outpatient Prospective Payment System (OPPS) Hospital Billing
(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Hospitals subject to OPPS (TOBs 12X and 13X) must use modifier -25 when billing the IPPE G0344 along with the technical component of the EKG, G0367, on the same claim. The same is true when billing IPPE code G0402 along with the technical component of the screening EKG, code G0404. This is due to an OPPS Outpatient Code Editor (OCE) which contains an edit that requires a modifier -25 on any evaluation and management (E/M) HCPCS code if there is also a status "S" or "T" HCPCS procedure code on the claim.

80.4 - Coinsurance and Deductible
(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

The Medicare deductible and coinsurance apply for the IPPE provided before January 1, 2009.

The Medicare deductible is waived effective for the IPPE provided on or after January 1, 2009. Coinsurance continues to apply for the IPPE provided on or after January 1, 2009.

As a result of the Affordable Care Act, effective for the IPPE provided on or after January 1, 2011, the Medicare deductible and coinsurance (for HCPCS code G0402 only) are waived.

80.5 - Medicare Summary Notices (MSNs)
(Rev. 1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

When denying additional claims for G0344, G0366, G0367 and G0368, A/B MACs (A) and (B) shall use MSN 18.22 - This service was denied because Medicare only covers the one-time initial preventive physical exam with an electrocardiogram within the first 6 months that you have Part B coverage, and only if that coverage begins on or after January 1, 2005.

The Spanish version is: 18.22 - Este servicio fue denegado porque Medicare solamente cubre un examen fisico preventivo con un electrocardiograma dentro de los primeros 6 meses que usted tenga cobertura de la Parte B, y sólo si esta cobertura comienza en o después del 1 de enero de 2005.

When denying additional claims for G0402 (or claims with dates of service beyond the 12 month period) A/B MACs (A) and (B) shall use MSN 20.91 - This service was denied. Medicare covers a one-time initial preventive physical exam (Welcome to Medicare physical exam) if you get it within the first 12 months of the effective date of your Medicare Part B coverage.

The Spanish version is: Este servicio fue negado. Medicare cubre un examen físico de "Bienvenido a Medicare" ofrecido una sola vez si se obtiene dentro de los primeros 12 meses de la fecha efectiva de su inscripción a la Parte B de Medicare.

When denying additional claims for screening EKG codes G0403, G0404 and G0405, A/B MACs (A) and (B) shall use MSN 20.12 - This service was denied because Medicare only covers this service once a lifetime.

The Spanish version is: Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida.

80.6 - Remittance Advice Remark Codes
(Rev. 1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

A/B MACs (A) and (B) shall use the appropriate claim Remittance Advice Remark code, such as N117 (This service is paid only once in a patient's lifetime) when denying additional claims for an IPPE and/or a screening EKG.

80.7 - Claims Adjustment Reason Codes
(Rev. 1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

A/B MACs (A) and (B) shall use the appropriate Claim Adjustment Reason code, such as 149 (Lifetime benefit maximum has been reached for this service/benefit category) when denying additional claims for an IPPE and/or a screening EKG.

80.8 - Advanced Beneficiary Notice (ABN) as Applied to the IPPE
(Rev. 1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

If a second IPPE is billed for the same beneficiary, it would be denied based on Section 1861(s)(2) of the Act, since the IPPE is a one-time benefit, and an ABN would not be required in order to hold the beneficiary liable for the cost of the second IPPE. However, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory 6-month period has lapsed since based on Section 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the initial 6-month period under the MMA of 2003. Effective for dates of service on or after January 1, 2009, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory 12-month period has lapsed since based on Section 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the initial 12-month period under the MIPPA of 2008.

90 - Diabetes Screening
(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

90.1 - HCPCS Coding for Diabetes Screening
(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

The following HCPCS codes are to be billed for diabetes screening:

82947 - Glucose, quantitative, blood (except reagent strip)
82950 - post-glucose dose (includes glucose)
82951 - tolerance test (GTT), three specimens (includes glucose)

90.2 - A/B MAC (B) Billing Requirements
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

Effective for dates of service January 1, 2005 and later, A/B MAC (B) shall recognize the above HCPCS codes for diabetes screening.

A/B MACs (B) shall pay for diabetes screening once every 12 months for a beneficiary that is not pre-diabetic. A/B MACs (B) shall pay for diabetes screening at a frequency of once every 6 months for a beneficiary that meets the definition of pre-diabetes.

A claim that is submitted for diabetes screening by a physician or supplier for a beneficiary that does not meet the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82947, 82950 or 82951 with a diagnosis code of V77.1 (if ICD-9-CM is applicable) or (if ICD-10-CM is applicable) diagnosis code Z13.1, encounter for screening for diabetes mellitis reported in the header.

90.2.1 - Modifier Requirements for Pre-diabetes

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

A claim that is submitted for diabetes screening and the beneficiary meets the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82497, 82950 or 82951 with an ICD-9-CM diagnosis code of V77.1 reported (if ICD-9-CM is applicable) or, if ICD-10-CM is applicable, a diagnosis code of Z13.1in the header. In addition, modifier "TS" (follow-up service) shall be reported on the line item.

90.3 - A/B MAC (A) Billing Requirements

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

Effective for dates of service January 1, 2005 and later, A/B MACs (A) shall recognize the above HCPCS codes for diabetes screening.

A/B MACs (A) shall pay for diabetes screening once every 12 months for a beneficiary that is not pre-diabetic. A/B MACs (A) shall pay for diabetes screening at a frequency of once every 6 months for a beneficiary that meets the definition of pre-diabetes.

A claim that is submitted for diabetes screening by a physician or supplier for a beneficiary that does not meet the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82947, 82950 or 82951 with an ICD-9-CM diagnosis code of V77.1 or, if ICD-10-CM is applicable, a diagnosis code of Z13.1.

90.3.1 - Modifier Requirements for Pre-diabetes

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

A claim that is submitted for diabetes screening and the beneficiary meets the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82497, 82950 or 82951 with a diagnosis code of V77.1 (if ICD-9-CM is applicable) or, if, ICD-10-CM is applicable, diagnosis code Z13.1. In addition, modifier "TS" (follow-up service) - shall be reported on the line item.

90.4 - Diagnosis Code Reporting

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

A claim that is submitted for diabetes screening shall include the diagnosis code V77.1 (if ICD-9-CM is applicable) or (if ICD-10-CM is applicable) diagnosis code Z13.1.

90.5 - Medicare Summary Notices

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

When denying claims for diabetes screening based upon a CWF reject for 82947, 82950 or 82951 reported with ICD-9-CM diagnosis code V77.1 or ICD-10-CM diagnosis code Z13.1, A/B MACs (A) and (B) shall use MSN 18.4, "This

service is being denied because it has not been 6 months since your last examination of this kind." (See chapter 30 section 40.3.6.4(c) for additional information on ABN's.)

90.6 - Remittance Advice Remark Codes
(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

A/B MACs (A) and (B) shall use the appropriate remittance advice notice that appropriately explains the denial of payment.

90.7 - Claims Adjustment Reason Codes
(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

A/B MACs (A) and (B) shall use the appropriate claims adjustment reason code such as 119 "Benefit maximum for this time period or occurrence has been reached."

100 - Cardiovascular Disease Screening
(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

100.1 - HCPCS Coding for Cardiovascular Disease Screening
(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

The following HCPCS codes are to be billed for Cardiovascular Disease Screening:

80061 - Lipid Panel
82465 - Cholesterol, serum or whole blood, total
83718 - Lipoprotein, direct measurement, high density cholesterol
84478 - Triglycerides

100.2 - A/B MAC (B) Billing Requirements
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

Effective for dates of service, January 1, 2005, and later, A/B MACs (B) shall recognize the above HCPCS codes for Cardiovascular Disease Screening.

A/B MACs (B) shall pay for Cardiovascular Disease Screening once every 60 months.

A claim that is submitted for Cardiovascular Disease Screening shall be submitted in the following manner:

The line item shall contain 80061, 82465, 83718 or 84478 with one of the following diagnoses:

If ICD-9-CM is applicable
V81.0 - Special screening for ischemic heart disease,
V81.1 - Special screening for hypertension or
V81.2 - Special screening for other and unspecified cardiovascular conditions

If ICD-10-CM is applicable
Z13.6 - encounter for screening for cardiovascular disease

The appropriate diagnosis codes are reported in the header and pointed to the line item.

100.3 - A/B MAC (A) Billing Requirements
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

Effective for dates of service, January 1, 2005, and later, A/B MACs (A) shall recognize the above HCPCS codes for Cardiovascular Disease Screening.

A/B MACs (A) shall pay for Cardiovascular Disease Screening once every 60 months.

A claim that is submitted for Cardiovascular Disease Screening shall be submitted in the following manner:

The line item shall contain 80061, 82465, 83718 or 84478 with one of the following diagnosis codes reported in the header:

If ICD-9-CM is applicable
V81.0 - Special screening for ischemic heart disease,
V81.1 - Special screening for hypertension or
V81.2 - Special screening for other and unspecified cardiovascular conditions

If ICD-10-CM is applicable
Z13.6 - encounter for screening for cardiovascular disease

100.4 - Diagnosis Code Reporting
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

A claim that is submitted for Cardiovascular Disease Screening shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

If ICD-9-CM is applicable
V81.0 - Special screening for ischemic heart disease,
V81.1 - Special screening for hypertension, or
V81.2 - Special screening for other and unspecified cardiovascular conditions

If ICD-10-CM is applicable
Z13.6 - encounter for screening for cardiovascular disease

100.5 - Medicare Summary Notice
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

When denying claims for cardiovascular screening based upon a CWF reject for 80061, 82465, 83718, or 84478 billed with one or more the of the following diagnosis codes, A/B MACs (A) and (B) shall use MSN 16.54 Medicare does not pay for this many services or supplies.

ICD-9-CM
V81.0, V81.1 or V81.2,

ICD-10-CM
Z13.6

100.6 - Remittance Advice Remark Codes
(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

A/B MACs (A) and (B) shall use the appropriate remittance advice notice that appropriately explains the denial of payment.

100.7 - Claim Adjustment Reason Code
(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

A/B MACs (A) and (B) shall use claims adjustment reason code 119 “Benefit maximum for this time period has been reached.”

110 - Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

Section 1861(s)(2)(AA) and 1861(bbb) of the Social Security Act and implementing regulations at 42 CFR 410.19 authorize coverage under Medicare Part B for a one-time ultrasound screening for abdominal aortic aneurysm (AAA), effective January 1, 2007.

110.1 - Definitions
(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

The term “ultrasound screening for abdominal aortic aneurysm” means the following services furnished to an asymptomatic individual for the early detection of an abdominal aortic aneurysm:

1. a procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, as specified by the Secretary of Health and Human Services, through the national coverage determination process) provided for the early detection of abdominal aortic aneurysms; and

2. includes a physician's interpretation of the results of the procedure.

110.2 - Coverage
(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

Payment may be made for a one-time ultrasound screening for AAA for beneficiaries who meet the following criteria:

(i) receives a referral for such an ultrasound screening from the beneficiary’s attending physician, physician assistant, nurse practitioner or clinical nurse specialist;

(ii) receives such ultrasound screening from a provider or supplier who is authorized to provide covered ultrasound diagnostic services;

(iii) has not been previously furnished such an ultrasound screening under the Medicare Program; and

(vi) is included in at least one of the following risk categories--

(I) has a family history of abdominal aortic aneurysm;

(II) is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime; or

(III) is a beneficiary who manifests other risk factors in a beneficiary category recommended for screening

by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determination process.

110.3 - Payment

(Rev. 1113, Issued: 11-17-06, Effective: 01-01-07, Implementation: 01-02-07)

If the screening is provided in a physician office, the service is billed to the A/B MAC (B) using the HCPCS code identified in section 110.3.2 below. Payment is under the Medicare Physicians Fee Schedule (MPFS).

A/B MACs (A) shall pay for the AAA screening only when the services are performed in a hospital, including a critical access hospital (CAH), Indian Health Service (IHS) Facility, Skilled Nursing Facility (SNF), Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC) and submitted on one of the following types of bills (TOBs): 12X, 13X, 22X, 23X, 71X, 73X, 85X.

The following describes the payment methodology for AAA Screening:

Facility	Type of Bill	Payment
Hospitals subject to OPPS	12X, 13X	OPPS
Method I and Method II Critical Access Hospitals (CAHs)	12X and 85X	101% of reasonable cost
IHS providers	13X, revenue code 051X	OMB-approved outpatient per visit all inclusive rate (AIR)
IHS providers	12X, revenue code 024X	All-inclusive inpatient ancillary per diem rate
IHS CAHs	85X, revenue code 051X	101% of the all-inclusive facility specific per visit rate
IHS CAHs	12X, revenue code 024X	101% of the all-inclusive facility specific per diem rate
SNFs **	22X, 23X	Non-facility rate on the MPFS
RHCs*	71X, revenue code 052X	All-inclusive encounter rate
FQHCs*	73X, revenue code 052X	All-inclusive encounter rate
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12X, 13X	94% of provider submitted charges or according to the terms of the Maryland Waiver

* If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the A/B MAC (A) using TOBs 71X and 73X, respectively, and the appropriate site of service revenue code in the 052X revenue code series.

If the screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the A/B MAC (B) under the practitioner's ID following instructions for submitting practitioner claims to the Medicare A/B MAC (B).

If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the A/B MAC (A) under the base provider's ID, following instructions for submitting claims to the A/B MAC (A) from the base provider.

** The SNF consolidated billing provision allows separate part B payment for screening services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a 22X bill type. Screening services provided by other provider types must be reimbursed by the SNF.

110.3.1 - Deductible and Coinsurance
(Rev. 3669, Issued: 12-02-16, Effective: 01-01-17, Implementation: 01-03-17)

The Part B deductible and coinsurance for screening AAA is waived.

110.3.2 - HCPCS Code
(Rev. 3669, Issued: 12-02-16, Effective: 01-01-17, Implementation: 01-03-17)

Effective for services furnished on or after January 1, 2007 through December 31, 2016, the following code and modifiers are used for AAA screening services:

> **G0389**: Ultrasound, B-scan and or real time with image documentation; for abdominal aortic aneurysm (AAA) screening
>
> **Short Descriptor:** Ultrasound exam AAA screen
>
> **Modifiers:** TC, 26

Effective for services furnished on or after January 1, 2017, the following code and modifiers, are used for AAA screening services:

> **76706**: Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA). (For screening ultrasound or duplex ultrasound of the abdominal aorta other than screening, see 76770, 76775, 93978, 93979.)
>
> **Short Descriptor:** Us abdl aorta screen AAA
>
> **Modifiers:** TC, 26

110.3.3 - Advance Beneficiary Notice
(Rev. 3669, Issued: 12-02-16, Effective: 01-01-17, Implementation: 01-03-17)

A/B MACs (A) and (B) will deny an AAA screening service billed more than once in a beneficiary's lifetime.

If a second AAA ultrasound screening is billed for the same beneficiary or if any of the other statutory criteria for coverage listed in section 1861(s)(2)(AA) of the Social Security Act are not met, the service would be denied as a statutory (technical) denial under section 1861(s)(2)(AA), not a medical necessity denial.

If a provider cannot determine whether or not the beneficiary has previously had an AAA screening, but all of the other statutory requirements for coverage have been met, the provider should issue the ABN-G. Likewise, if all of the statutory requirements for coverage have been met, but a question of medical necessity still exists, the provider should issue the ABN-G.

110.3.4 - RHCs/FQHCs Special Billing Instructions

(Rev. 3669, Issued: 12-02-16, Effective: 01-01-17, Implementation: 01-03-17)

Detailed billing instructions for ultrasound screening for AAA screenings provided in RHCs and FQHCs can be found in chapter 9, section 70.3 of this manual.

120 - Diabetes Self-Management Training (DSMT) Services

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, section 300 for information on coverage requirements, certified providers and enrollment.

120.1 - Coding and Payment of DSMT Services

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The following HCPCS codes are used to report DSMT:

- G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes.
- G0109 - Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

The type of service for these codes is 1.

Payment to physicians and providers for outpatient DSMT is made as follows:

Type of Facility	Payment Method	Type of Bill
Physician (billed to the A/B MAC (B))	MPFS	NA
Hospitals subject to OPPS	MPFS	12X, 13X
Method I and Method II Critical Access Hospitals (CAHs) (technical services)	101% of reasonable cost	12X and 85X
Indian Health Service (IHS) providers billing hospital outpatient Part B	OMB-approved outpatient per visit all inclusive rate (AIR)	13X
IHS providers billing inpatient Part B	All-inclusive inpatient ancillary per diem rate	12X

Type of Facility	Payment Method	Type of Bill
IHS CAHs billing outpatient Part B	101% of the all-inclusive facility specific per visit rate	85X
IHS CAHs billing inpatient Part B	101% of the all-inclusive facility specific per diem rate	12X
FQHCs*	All-inclusive encounter rate with other qualified services. Separate visit payment available with HCPCS.	73X
Skilled Nursing Facilities **	MPFS non-facility rate	22X, 23X
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	94% of provider submitted charges in accordance with the terms of the Maryland Waiver	12X, 13X
Home Health Agencies (can be billed only if the service is provided outside of the treatment plan)	MPFS non-facility rate	34X

* Effective January 1, 2006, payment for DSMT provided in an FQHC that meets all of the requirements as above, may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed on TOB 73X, with HCPCS G0108 or G0109, and revenue codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900.

** The SNF consolidated billing provision allows separate part B payment for training services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a 22 bill type. Training services provided by other provider types must be reimbursed by X the SNF.

NOTE: An ESRD facility is a reasonable site for this service, however, because it is required to provide dietician and nutritional services as part of the care covered in the composite rate, ESRD facilities are not allowed to bill for it separately and do not receive separate reimbursement. Likewise, an RHC is a reasonable site for this service, however it must be provided in an RHC with other qualifying services and paid at the all-inclusive encounter rate.

Deductible and co-insurance apply.

120.2 - Bill Processing Requirements

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

See Pub. 100-04, chapter 25 for instructions for A/B MACs (A) and (HHH).

See Pub. 100-04, chapter 26 for instructions for A/B MACs (B).

Billing is to the "certified provider's" regular A/B MAC (A), (B), or (HHH), i.e., there are no specialty contractors for this service. (See Pub 100-02, chapter 15, section 300.2 for the definition of "certified provider" in this instance.)

120.2.1 - Special Processing Instructions for Billing Frequency Requirements

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The frequency editing for DSMT is performed in CWF as follows:

A - Initial Training

The initial year for DSMT is the '12' month period following the initial date. When a claim contains a DSMT HCPCS code and the associated units cause the total time for the DSMT initial year to exceed '10' hours, a CWF error will set.

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, section 300 for information on coverage for initial training.

B - Follow-Up Training

Follow-up training for subsequent years are based on a 12 month calendar year after the initial year. However, if the beneficiary exhausts 10 hours in the initial year then the beneficiary would be eligible for follow-up training in the next calendar year. When a claim contains a DSMT HCPCS code and the associated units cause the total time for any follow-up year to exceed 2 hours, a CWF error will set.

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, section 300 for information on coverage for follow-up training.

C - Examples

Example # 1 -- Beneficiary Exhausts 10 hours in the Initial Year (12 continuous months)

Bene receives first service: April, 2006
Bene completes initial 10 hours DSMT training: April, 2007
Bene is eligible for follow-up training: May 2007 (13^{th} month begins the subsequent year)
Bene completes follow-up training: December, 2007
Bene is eligible for next year follow-up training: January, 2008

Example # 2 Beneficiary Exhausts 10 hours Within the Initial Calendar Year

Bene receives first service: April 2006
Bene completes initial 10 hours of DSMT training, December 2006
Bene is eligible for follow-up training: January, 2007
Bene completes follow-up training: July 2007
Bene is eligible for next year follow-up training: January 2008

120.2.2 - Advance Beneficiary Notice (ABN) Requirements

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The beneficiary is liable for services denied over the limited number of hours with referrals for DSMT. An ABN should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable.

An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their State but who have not obtained Medicare Provider Numbers.

120.2.3 - RHCs/FQHCs Special Billing Instructions

(Rev. 3669, Issued: 12-02-16, Effective: 01-01-17, Implementation: 01-03-17)

Detailed billing instructions for DSMT services provided in RHCs and FQHCs can be found in chapter 9, section 70.5 of this manual.

120.3 - Duplicate Edits

(Rev. 1846; Issued: 11-06-09; Effective Date: 04-01-10; Implementation Date: 04-05-10)

There are CWF edits applicable to DSMT. Refer to chapter 4, section 300.6 of this manual for a description of these instructions.

130 - Human Immunodeficiency Virus (HIV) Screening Tests

(Rev. 3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17)

130.1 - Healthcare Common Procedure Coding System (HCPCS) for HIV Screening Tests

(Rev. 3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17)

Effective for claims with dates of service on and after December 8, 2009, implemented with the April 5, 2010, IOCE, the following HCPCS codes are to be billed for human immunodeficiency virus (HIV) screening:

- G0432- Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening,

- G0433 - Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening, and,

- G0435 - Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening.

In addition to the above codes, effective for claims with dates of service on or after April 13, 2015, the following HCPCS/CPT code may also **be billed for HIV screening:**

- G0475 - HIV antigen/antibody, combination assay, screening
- 80081 - Obstetric panel

130.2 - Billing Requirements

(Rev. 3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17)

Medicare Administrative Contractors (MACs) shall recognize the above HCPCS codes for HIV screening in accordance with Publication 100-03, Medicare National Coverage Determinations Manual, section 210.7.

Effective for claims with dates of service on and after December 8, 2009, MACs shall pay for voluntary HIV screening as follows:

- A maximum of once annually for beneficiaries at increased risk for HIV infection (11 full months must elapse following the month the previous test was performed in order for the subsequent test to be covered), and,

- A maximum of three times per term of pregnancy for pregnant Medicare beneficiaries beginning with the date of the first test when ordered by the woman's clinician.

Claims that are submitted for HIV screening shall be submitted in the following manner:

For beneficiaries reporting increased risk factors, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 (Special screening for other specified viral disease) as primary, and V69.8 (Other problems related to lifestyle), as secondary.

For beneficiaries not reporting increased risk factors, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 only.

For pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 as primary, and one of the following ICD-9 diagnosis codes: V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy), as secondary.

Effective for claims with dates of service on or after April 13, 2015, MACs shall also pay for voluntary, HIV screening as follows (replacing ICD-9 with ICD-10 beginning October 1, 2015):

For pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, G0435, G0475 or CPT-80081 with primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4, along with one of the following ICD-9/ICD-10 diagnosis codes as secondary listed below, and allow no more than 3 HIV screening tests during each term of pregnancy beginning with the date of the 1st test:

ICD-9: V22.0 Supervision of normal first pregnancy
ICD-10: Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01 Encounter for supervision of normal first pregnancy, first trimester
Z34.02 Encounter for supervision of normal first pregnancy, second trimester
Z34.03 Encounter for supervision of normal first pregnancy, third trimester
ICD-9: V22.1 Supervision of other normal pregnancy
ICD-10: Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81 Encounter for supervision of other normal pregnancy, first trimester
Z34.82 Encounter for supervision of other normal pregnancy, second trimester
Z34.83 Encounter for supervision of other normal pregnancy, third trimester
Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester
ICD-9: V23.9 Supervision of unspecified high-risk pregnancy
ICD-10: O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91 Supervision of high risk pregnancy, unspecified, first trimester
O09.92 Supervision of high risk pregnancy, unspecified, second trimester
O09.93 Supervision of high risk pregnancy, unspecified, third trimester

For non-pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, G0435, or G0475 for beneficiaries between 15 and 65 years of age one time per annum with ICD-9/ICD-10 diagnosis code V73.89/Z11.4 as primary regardless of risk factors. If primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4 is not present and the beneficiary is between 15 and 65 years of age, or the service is billed more than one time per annum, the detail line shall be denied.

For non-pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, G0435, or G0475 for beneficiaries less than 15 and greater than 65 years of age one time per annum with ICD-9/ICD-10 diagnosis code V73.89/ Z11.4 as primary, and one of the following secondary ICD-9/ICD-10 diagnosis codes:

V69.8 (Other problems related to lifestyle)/Z72.89 (Other problems related to lifestyle)
Z72.51 (High risk heterosexual behavior)
Z72.52 (High risk homosexual behavior)
Z72.53 (High risk bisexual behavior)

If ICD-9/ICD-10 diagnosis code V73.89/Z11.4 is not present as primary and one of the ICD-9/ICD-10 secondary codes listed above is not present and the beneficiary is less than 15 or greater than 65 years of age, or the service is billed more than one time per annum, the detail line shall be denied.

130.3 - Payment Method

(Rev. 3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17)

Payment for HIV screening, HCPCS codes G0432, G0433, G0435, is under the Medicare Clinical Laboratory Fee Schedule (CLFS) for Types of Bill (TOB) 12X, 13X, 14X, 22X, and 23X beginning January 1, 2011. For TOB 85X payment is based on reasonable cost. Deductible and coinsurance do not apply. Between December 8, 2009, and April 4, 2010, these services can be billed with unlisted procedure code 87999. Between April 5, 2010, and January 1, 2011, HCPCS codes G0432, G0433, and G0435 will be contractor priced.

Payment for HIV screening, HCPCS code G0475, for institutional claims will be under the Medicare CLFS for TOB 12X, 13X, 14X, 22X, and 23X for claims on or after January 1, 2017. For TOB 85X payment is based on reasonable cost.

Effective for claims with date of service from April 13, 2015 through December 31, 2016, HCPCS code G0475 will be contractor priced. Beginning with date of service January 1, 2017 and after, HCPCS code G0475 will be priced and paid according to the CLFS.

HCPCS code G0475 will be included in the January 2017 CLFS, January 1, 2016 IOCE, the January 2016 OPPS and January 1, 2016 MPFSD. HCPCS code G0475 will be effective retroactive to April 13, 2015 in the IOCE & OPPS.

A/B MACs (B) shall only accept claims submitted with a G0475, G0432, G0433, or G0435 with a Place of Service (POS) Code equal to 81 Independent Lab, and 11, Office.

Deductible and coinsurance do not apply.

130.4 - Types of Bill (TOBs) and Revenue Codes

(Rev. 3461; Issued: 02-05-16; Effective: 04-13-15; Implementation: 03-07-16 - non-shared A/B MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement 9403.04.9)

The applicable bill types for HIV screening, HCPCS codes G0432, G0433, G0435, and G0475 are: 12X, 13X, 14X, 22X, 23X, and 85X. (Effective April 1, 2006, TOB 14X is for non-patient laboratory specimens.) Use revenue code 030X (laboratory, clinical diagnostic).

A/B MACs (A) shall apply contractor pricing for HCPCS code G0475, HIV screening, for claims with dates of service on and after April 13, 2015 through December 31, 2016.

130.5 - Diagnosis Code Reporting

(Rev. 3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17) A claim that is submitted for HIV screening shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

a. For claims where increased risk factors are reported: ICD-9/ICD-10 diagnosis code V73.89/Z11.4 as primary and ICD-9/ICD-10 diagnosis code V69.8/Z72.89, Z72.51, Z72.52, or Z72.53, as secondary.

b. For claims where increased risk factors are NOT reported: ICD-9/ICD-10 diagnosis code V73.89/Z11.4 as primary only.

c. For claims for pregnant Medicare beneficiaries, the following secondary diagnosis codes shall be submitted in addition to primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4 to allow for more frequent screening than once per 12-month period:

ICD-9: V22.0 Supervision of normal first pregnancy
ICD-10: Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01 Encounter for supervision of normal first pregnancy, first trimester
Z34.02 Encounter for supervision of normal first pregnancy, second trimester
Z34.03 Encounter for supervision of normal first pregnancy, third trimester

ICD-9: V22.1 Supervision of other normal pregnancy
ICD-10: Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81 Encounter for supervision of other normal pregnancy, first trimester
Z34.82 Encounter for supervision of other normal pregnancy, second trimester
Z34.83 Encounter for supervision of other normal pregnancy, third trimester
Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester

ICD-9: V23.9 Supervision of unspecified high-risk pregnancy
ICD-10: O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91 Supervision of high risk pregnancy, unspecified, first trimester
O09.92 Supervision of high risk pregnancy, unspecified, second trimester
O09.93 Supervision of high risk pregnancy, unspecified, third trimester

130.6 - Medicare Summary Notice (MSN) and Claim Adjustment Reason Codes (CARCs)

(Rev. 3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17)

Effective for dates of service on or after December 8, 2009, when denying claims for HIV screening, HCPCS codes G0432, G0433, or G0435, submitted without ICD-9/ICD-10 diagnosis codes V73.89/Z11.4, or V73.89/Z11.4 and V69.8/Z72.89, use the following messages:

Medicare Summary Notice (MSN) 16.10 - Medicare does not pay for this item or service.

“Medicare no paga por este articulo o servicio”

Claim Adjustment Reason Code (CARC) 167- This (these) diagnosis(es) is (are) not covered.

Group Code CO - (Contractual Obligation)

- Effective for dates of service on or after December 8, 2009, when denying claims for HIV screening, HCPCS codes G0432, G0433, or G0435, over the benefit maximum, use the following denial messages:

  MSN 15.22 – The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service.

  "La informacíón proporcionada no justifica la necesidad de esta cantidad de servicios o articulos en este periodo de tiempo por lo cual Medicare no pagará por este articulo o servicio."

  CARC 119 – Benefit maximum for this time period or occurrence has been reached.

  Group Code CO - (Contractual obligation).

- Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS code G0432, G0433, G0435, G0475 or CPT-80081 for more than three in a pregnancy term, use the following denial messages:

  CARC 119 – Benefit maximum for this time period or occurrence has been reached.

  Remittance Advice Remark Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

  (Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

  Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800 MEDICARE (1-800-633-4227).

  MSN 15.20: "The following policies NCD210.7 were used when we made this decision."

  Spanish Version – "Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decisión."

  NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

  MSN: 15.22: "The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service.

  Spanish Version – "La información proporcionada no justifica la necesidad de esta cantidad de servicios o artículos en este periodo de tiempo por lo cual Medicare no pagará por este artículo o servicio."

Group Code - CO

- Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS code G0475, if ICD-9/ICD-10 primary diagnosis code V73.89/Z11.4 and one of the following secondary ICD-9/ICD-10

diagnosis codes: V69.2/Z72.51, V69.8/Z72.89, V69.2/Z72.52, or V69.2/Z72.53 are not present and the beneficiary is less than 15 and greater than 65 years of age, use the following messages:

CARC 6: “The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

RARC N129: “Not eligible due to the patient’s age.”

(Part A only) MSN 15.19: “Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD”.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: “The following policies NCD210.7 were used when we made this decision."

Spanish Version – “Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decisión.”

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

Group Code - CO

- Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS code G0475, G0432, G0433, or G0435 is not submitted with the appropriate, primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4, , use the following messages:

CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

(Part A Only) MSN 15.19: “Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD”.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: “The following policies NCD210.7 were used when we made this decision.”

Spanish Version – “Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decisión.”

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

Group Code - CO

Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS code G0475, billed more than once per annum [at least 11 full months must elapse from the date of the last screening], use the following messages:

CARC 119: "Benefit maximum for this time period or occurrence has been reached."

RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

(Part A Only)MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policy NCD210.7 was used when we made this decision"

Spanish Version – "Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decisión."

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

Group Code - CO

- Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS G0475 or CPT-80081 if ICD-9/ICD-10 primary diagnosis code V73.89/Z11.4 and one of the following ICD-9/ICD-10 secondary diagnosis codes are not present for pregnant beneficiaries as listed in section 130.5 (c), use the following denial messages:

CARC 11: The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.

RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

Group Code CO

(Part A Only) MSN 15.19: “Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD”.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: “The following policies NCD210.7 were used when we made this decision.”

Spanish Version – “Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decision.”

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

- Effective for dates of service on or after April 13, 2015, when denying claims for CPT 80081 when submitted with one of the following secondary diagnosis codes denoting pregnancy, but the required HIV primary diagnosis codes listed below is not present:

For ICD-9: V22.0, V22.1, V23.9
For ICD-10: Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83,Z34,90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93
Use the following denial messages:

CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

(Part A Only) MSN 15.19: “Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD”.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: “The following policies NCD210.7 were used when we made this decision.”

Spanish Version – “Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decisión.”

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

Group Code – CO

- Effective for dates of service on or after April 13, 2015, when denying claims for HCPCS 80081when the line – item is submitted with one of the following required HIV primary diagnosis codes:

  For ICD-9: V73.89

  For ICD-10: Z11.4

And none of the following secondary diagnosis codes denoting pregnancy are present.

For ICD-9: V22.0, V22.1, V23.9

For ICD-10: Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93

Use the following denial messages,

CARC 11:
This diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386:
"This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

Group Code: CO (Contractual Obligation)

(Part A only) MSN 15.19:
"Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD 210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD 210.7 fueron utilizadas cuando se tomó esta decisión."

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

- Effective for dates of service on or after April 13, 2015, when denying line level claims for G0475, G0432, G0433, G0435 or the CPT code 80081 is submitted with one of the pregnancy secondary diagnosis codes, but the Sex Code on the claim indicates 'Male', use the following denial messages:

CARC 7: The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Group Code: CO (Contractual Obligation)

(Part A only) MSN 15.19:
"Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-+-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD 210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD 210.7 fueron utilizadas cuando se tomó esta decisión."

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

- Effective for dates of service on or after April 13, 2015, when denying line-items with POS other than 11 (Office) or 81 (Independent Lab) for the HIV screenings HCPCS G0475, G0432, G0433 and 'G0435, use the following denial messages:

CARC 171 – Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
RARC N428 - Not covered when performed in certain settings.

Group Code: CO (Contractual Obligation)

MSN 21.25 - This service was denied because Medicare only covers this service in certain settings.

Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

MSN 15.19:
"Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD 210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD 210.7 fueron utilizadas cuando se tomó esta decisión."

140 - Annual Wellness Visit (AWV)
(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Pursuant to section 4103 of the Affordable Care Act of 2010, the Centers for Medicare & Medicaid Services (CMS) amended section 411.15(a)(1) and 411.15(k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This expanded coverage is subject to certain eligibility and other limitations that allow payment for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months.

The AWV will include the establishment of, or update to, the individual's medical/family history, measurement of his/her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and encouraging patients to obtain the screening and preventive services that may already be covered and paid for under Medicare Part B. CMS amended 42 CFR §§411.15(a)(1) and 411.15(k)(15) to allow payment on or after January 1, 2011, for an AWV (as established at 42 CFR 410.15) when performed by qualified health professionals.

Coverage is available for an AWV that meets the following requirements:

1. It is performed by a health professional;

2. It is furnished to an eligible beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and he/she has not received either an IPPE or an AWV providing PPPS within the past 12 months.

See Pub. 100-02,Medicare Benefit Policy Manual, chapter 15, section 280.5, for detailed policy regarding the AWV, including definitions of: (1) detection of cognitive impairment, (2) eligible beneficiary, (3) establishment of, or an update to, an individual's medical/family history, (4&5) first and subsequent AWVs providing PPPS, (6) health professional, and, (7) review of an individual's functional ability/level of safety.

140.1 - Healthcare Common Procedure Coding System (HCPCS) Coding for the AWV
(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

The HCPCS codes listed below were developed for the AWV benefit effective January 1, 2011, for individuals whose initial enrollment is on or after January 1, 2011.

G0438 - Annual wellness visit; includes a personalized prevention plan of service (PPPS); first visit

G0439 - Annual wellness visit; includes a personalized prevention plan of service (PPPS); subsequent visit

140.2 - A/B MAC (B) Billing Requirements
(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Effective for dates of service on and after January 1, 2011, A/B MACs (B) shall recognize HCPCS codes G0438 and G0439 shown above in section 140.1 for billing AWVs. The type of service (TOS) for each of the new codes is 1. AWV services are paid under the Medicare Physician Fee Schedule (MPFS).

For further instructions regarding practitioner reporting of HCPCS codes G0438 and G0439 under different clinical scenarios, see chapter 12, sections 30.6.1.1 and 100.1.1 of this manual.

140.3 - A/B MAC (A) Billing Requirements
(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

The A/B MAC (A) will pay for AWV services only when submitted on one of the following types of bill (TOBs): 12X, 13X, 22X, 23X, 71X, 77X, and 85X. Type of facility and setting determines the basis of payment:

- For services performed on a 12X TOB and 13X TOB, hospital inpatient Part B and hospital outpatient, payment shall be made under the MPFS.
- For services performed in a skilled nursing facility, TOB 22X and TOB 23X, make payment based on the MPFS.
- For services performed on a 71X TOB, rural health clinic (RHC) or 77X TOB, Federally Qualified Health Center (FQHC), payment is made based on an all-inclusive rate and the AWV does not qualify for separate payment with another encounter.
- For services performed on an 85X TOB, Critical Access Hospital (CAH), pay based on reasonable cost.
- For services performed on an 85X TOB, CAH Method II, payment is based on the MPFS.
- For inpatient or outpatient services in hospitals in Maryland, make payment according to the Health Services Cost Review Commission.

Only CAHs paid under the optional method are paid for professional services for the AWV (in addition to the facility payment) when those charges are reported under revenue codes 096X, 097X, or 098X.

140.4 - Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) Special Billing Instructions
(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Beginning with dates of service on or after January 1, 2011, if an AWV is provided in an RHC or FQHC, the professional portion of the service is billed to the A/B MAC (A) using TOBs 71X and 77X, respectively, and must include HCPCS code G0438 or G0439. Deductible and coinsurance do not apply.

140.5 - Coinsurance and Deductible
(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Sections 4103 and 4104 of the Affordable Care Act provide for a waiver of Medicare coinsurance/copayment and Part B deductible requirements for the AWV effective for services furnished on or after January 1, 2011.

140.6 - Common Working File (CWF) Edits
(Rev. 2575, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

Effective for claims with dates of service on and after January 1, 2011, CWF shall reject:

- AWV claims for G0438 when a previous (first) AWV, HCPCS code G0438, is paid in history regardless of when it occurred.
- AWV claims when a previous AWV, G0438 or G0439, is paid in history within the previous 12 months.

- Beginning January 1, 2011, AWV claims when a previous IPPE, HCPCS code G0402, is paid in history within the previous 12 months.

- AWV claims (G0438 and G0439) billed for a date of service within 12 months after the effective date of a beneficiary's first Medicare Part B coverage period.

The following change shall be effective for claims processed on or after April 1, 2013. Typically, when a preventive service is posted to a beneficiary's utilization history, separate entries are posted for a "professional" service (the professional claim for the delivery of the service itself) and a "technical" service (the institutional claims for a facility fee). However, in the case of AWV services, since there is no separate payment for a facility fee, the AWV claim will be posted as the "professional" service only, regardless of whether it is paid on a professional claim or an institutional claim.

140.7 - Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claims Adjustment Reason Codes (CARCs), and Advance Beneficiary Notices (ABNs)

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

Messages for A/B MACs (A) and (B):

When paying claims for an AWV, A/B MACs (A) and (B) shall use the following Medicare Summary Notices (MSNs):

MSN: 18.25: - "Your Annual Wellness Visit has been approved. You will qualify for another Annual Wellness Visit 12 months after the date of this visit."

Spanish Version "Su Visita Anual de Bienestar ha sido aprobada. Usted tendrá derecho a otra Visita Anual de Bienestar 12 meses después de la fecha de esta visita."

When denying claims for a first AWV, HCPCS G0438, when a first AWV, HCPCS G0438, is already paid in history, A/B MACs (A) and (B) shall use the following messages:

MSN 20.12: - "This service was denied because Medicare only covers this service once a lifetime."

Spanish Version: "Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida."

CARC 149: "Lifetime benefit maximum has been reached for this service/benefit category."

RARC N117: "This service is paid only once in a patient's lifetime**.**

Group Code - PR

When denying claims for a subsequent AWV, HCPCS G0439, because a previous AWV, HCPCS G0438 or G0439, is paid in history within the past 12 months, A/B MACs (A) and (B) shall use the following messages:

MSN 18.26: "This service was denied because it occurred too soon after your last covered Annual Wellness Visit. Medicare only covers one Annual Wellness Visit within a 12 month period."

Spanish Version: "Este servicio fue negado porque ocurrió antes del período de 12 meses de su última Visita Anual de Bienestar. Medicare sólo paga por una Visita Anual de Bienestar dentro de un período de 12 meses."

CARC 119: “Benefit maximum for this time period or occurrence has been reached.”

RARC N130 “Consult plan benefit documents/guidelines for information about restrictions for this service.”

Group Code - PR

When denying claims for an AWV, HCPCS G0438 or G0439, because an IPPE, HCPCS G0402, is paid in history with the past 12 months, A/B MACs (A) and (B) shall use the following messages:

(New) MSN 18.27: “This service was denied because it occurred too soon after your Initial Preventive Physical Exam.”

Spanish Version: “Este servicio fue negado porque ocurrió demasiado pronto después de su examen físico preventivo inicial.”

CARC 119: “Benefit maximum for this time period or occurrence has been reached.”

RARC N130: “Consult plan benefit documents/guidelines for information about restrictions for this service.”

Group Code - PR

When denying claims for an AWV, HCPCS G0438 or G0439, because the services were rendered within the first 12 months after the effective date of a beneficiary’s first Medicare Part B coverage period, A/B MACs (A) and (B) shall use the following messages:

(New) MSN 18.24: “This service was denied. Medicare doesn’t cover an Annual Wellness Visit within the first 12 months of your Medicare Part B coverage. Medicare does cover a one-time initial preventive physical exam (“Welcome to Medicare” physical exam) within the first 12 months of your Medicare Part B coverage”.

Spanish Version: “Este servicio fue negado. Medicare no cubre la Visita Anual de Bienestar durante los primeros 12 meses de su inscripción a la Parte B de Medicare. Medicare cubre un examen físico preventivo ("Bienvenido a Medicare") durante los primeros 12 meses de su inscripción a la Parte B de Medicare.”

CARC 26: “Expenses incurred prior to coverage”

RARC N130: “Consult plan benefit documents/guidelines for information about restrictions for this service.”

Group Code - PR

140.8 – Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)

(Rev. 10456, Issued: 11-13-20, Effective: 04-01-21, Implementation: 04-05-21)

For services furnished on or after January 1, 2016, Advance Care Planning (ACP) is treated as a preventive service when furnished with an AWV. The Medicare coinsurance and Part B deductible are waived for ACP when furnished as an optional element of an AWV.

The codes for the optional ACP services furnished as part of an AWV are 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate;) and an add-on code 99498 (each additional 30 minutes (List separately in

addition to code for primary procedure)). When ACP services are provided as a part of an AWV, practitioners would report CPT code 99497 (and add-on CPT code 99498 when applicable) for the ACP services in addition to either of the AWV codes (G0438 or G0439).

Note: ACP services are payable in hospice (Types of Bill 081x or 082x) when not part of the AWV when the services are performed by attending physicians that are employed by, or under arrangement with, the hospice.

150 - Counseling to Prevent Tobacco Use

(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively. See Chapter 32 section 12 for coverage and billing requirements for smoking cessation services.

Note: For claims effective 10/1/16. CPT Codes 99406 or 99407 used for processing NCD210.4.1

NOTE: Instructions in sections 150 thru 150.4 are no longer valid.

Effective for claims with dates of service on and after August 25, 2010, the Centers for Medicare & Medicaid Services (CMS) will cover counseling to prevent tobacco use services for outpatient and hospitalized Medicare beneficiaries:

- Who use tobacco, regardless of whether they have signs or symptoms of tobacco- related disease;
    - Who are competent and alert at the time that counseling is provided; and,
- Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations.

Conditions of Medicare Part A and Medicare Part B coverage for counseling to prevent tobacco use are located in the Medicare National Coverage Determinations (NCD) Manual, Publication 100-3, chapter1, section 210.4.1.

NOTE: Effective 9/30/15, NCD210.4 has been deleted from Pub. 100-03 NCD Manual. See NCD210.4.1 for remaining NCD re: Counseling to Prevent Tobacco Use.

150.1 - Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Coding

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes

up to 10 minutes) or 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively. See Chapter 32 section 12 for coverage and billing requirements for smoking cessation services.

The CMS has created two new CPT codes for billing for tobacco cessation counseling services to prevent tobacco use for those individuals who use tobacco but do not have signs or symptoms of tobacco-related disease.

The two CPT codes 99406 or 99407 that currently are used for smoking and tobacco-use cessation counseling for symptomatic individuals.

NOTE: The above G codes will not be active in A/B MAC (A), (B), and (HHH) systems until January 1, 2011. Therefore, A/B MACs (A), (B), and (HHH) shall advise non- outpatient perspective payment system (OPPS) providers to use unlisted code 99199 to bill for counseling to prevent tobacco use and tobacco-related disease services during the interim period of August 25, 2010, through December 31, 2010.

On January 3, 2011, A/B MAC (A), (B), and (HHH) systems will accept the new G codes for services performed on or after August 25, 2010.

Two new C codes have been created for facilities paid under OPPS when billing for counseling to prevent tobacco use and tobacco-related disease services during the interim period of August 25, 2010, through December 31, 2010:

C9801 - Smoking and tobacco cessation counseling visit for the asymptomatic patient, intermediate, greater than 3 minutes, up to 10 minutes

Short descriptor: Tobacco-use counsel 3-10 min

C9802 - Smoking and tobacco cessation counseling visit for the asymptomatic patient, intensive, greater than 10 minutes

Short descriptor: Tobacco-use counsel >10min

Claims for smoking and tobacco use cessation counseling services 99406 or 99407 shall be submitted with the applicable diagnosis codes:

ICD-10 CM Code	Code Description
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17.220	Nicotine dependence, chewing tobacco, uncomplicated
F17.221	Nicotine dependence, chewing tobacco, in remission
F17.223	Nicotine dependence, chewing tobacco, with withdrawal
F17.228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17.229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
F17.290	Nicotine dependence, other tobacco product, uncomplicated
F17.291	Nicotine dependence, other tobacco product, in remission
F17.293	Nicotine dependence, other tobacco product, with withdrawal
F17.298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17.299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
T65.211A	Toxic effect of chewing tobacco, accidental (unintentional), initial encounter
T65.212A	Toxic effect of chewing tobacco, intentional self-harm, initial encounter
T65.213A	Toxic effect of chewing tobacco, assault, initial encounter
T65.214A	Toxic effect of chewing tobacco, undetermined, initial encounter
T65.221A	Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter
T65.222A	Toxic effect of tobacco cigarettes, intentional self-harm, initial encounter
T65.223A	Toxic effect of tobacco cigarettes, assault, initial encounter
T65.224A	Toxic effect of tobacco cigarettes, undetermined, initial encounter
T65.291A	Toxic effect of other tobacco and nicotine, accidental (unintentional), initial encounter
T65.292A	Toxic effect of other tobacco and nicotine, intentional self-harm, initial encounter
T65.293A	Toxic effect of other tobacco and nicotine, assault, initial encounter
T65.294A	Toxic effect of other tobacco and nicotine, undetermined, initial encounter
Z72.0	Tobacco use effective October 1, 2024
Z87.891	Personal history of nicotine dependence

A/B MAC (A), (B), and (HHH) shall allow payment for a medically necessary E/M service on the same day as the smoking and tobacco-use cessation counseling service when it is clinically appropriate. Physicians and qualified non-physician practitioners shall use an appropriate HCPCS code to report an E/M service with modifier -25 to indicate that the E/M service is a separately identifiable service from 99406 or 99407.

150.2 - A/B MACs (B) Billing Requirements

(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

A/B MACs (B) shall pay for counseling to prevent tobacco use services billed with code G0436 or G0437 for dates of service on or after January 1, 2011. A/B MACs (B) shall pay for counseling services billed with code 99199 for dates of service performed on or after August 25, 2010 through December 31, 2010. The type of service (TOS) for each of the new codes is 1.

A/B MACs (B) pay for counseling services billed based on the Medicare Physician Fee Schedule (MPFS). Deductible and coinsurance apply for services performed on August 25, 2010, through December 31, 2010. For claims with dates of service on and after January 1, 2011, coinsurance and deductible do not apply on G0436 and G0437.

Physicians or qualified non-physician practitioners shall bill the A/B MACs (B) for counseling to prevent tobacco use services on Form CMS-1500 or an approved electronic format.

NOTE: The above G codes will not be active in MACs' systems until January 1, 2011. Therefore, MACs shall advise providers to use unlisted code 99199 to bill for counseling to prevent tobacco use services during the interim period of August 25, 2010, through December 31, 2010.

NOTE: Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively.

150.2.1 - A/B MAC (A) and (HHH) Billing Requirements

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

The A/B MACs (A) and (HHH) shall pay for counseling to prevent tobacco use services with codes G0436 and G0437 for dates of service on or after January 1, 2011. A/B MACs (A) and (HHH) shall pay for counseling services billed with code 99199 for dates of service performed on or after August 25, 2010, through December 31, 2010. For facilities paid under OPPS, A/B MACs (A) shall pay for counseling services billed with codes C9801 and C9802 for dates of service performed on or after August 25, 2010, through December 31, 2010.

Claims for counseling to prevent tobacco use services should be submitted on Form CMS-1450 or its electronic equivalent.

The applicable bill types are 12X, 13X, 22X, 23X, 34X, 71X, 77X, and 85X.

Applicable revenue codes are as follows:

Provider Type	Revenue Code
Rural Health Centers (RHCs)	052X
Federally Qualified Health Centers (FQHCs)	052x, 0519
Indian Health Services (IHS)	0510
Critical Access Hospitals (CAHs) Method II	096X, 097X, 098X
All Other Providers	0942

NOTE: When these services are provided by a clinical nurse specialist in the RHC/FQHC setting, they are considered "incident to" and do not constitute a billable visit.

The applicable bill types are 12X, 13X, 22X, 23X, 34X, 71X, 77X, and 85X. Payment for outpatient services is as follows:

Type of Facility	Method of Payment
Rural Health Centers (RHCs) Type of Bill (TOB) 71X	All-inclusive rate (AIR) for the encounter
Federally Qualified Health Centers (FQHCs) TOB 77X	FQHC Prospective Payment System (PPS) for the encounter
Hospitals TOBs 12X and 13X	OPPS for hospitals subject to OPPS MPFS for hospitals not subject to OPPS
Indian Health Services (IHS) Hospitals TOB 13X	AIR for the encounter
Skilled Nursing Facilities (SNFs) TOBs 22X and 23X	Medicare Physician Fee Schedule (MPFS)
Home Health Agencies (HHAs) TOB 34X	MPFS
Critical Access Hospitals (CAHs) TOB 85X	Method I: Technical services are paid at 101% of reasonable cost. Method II: technical services are paid at 101% of reasonable cost, and Professional services are paid at 115% of the MPFS Data Base
IHS CAHs TOB 85X	Based on specific rate
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC). That is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

Deductible and coinsurance apply for services performed on August 25, 2010, through December 31, 2010. For claims with dates of service on and after January 1, 2011, coinsurance and deductible do not apply for G0436 and G0437.

Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively

NOTE: Section 4104 of ACA provided for a waiver of Medicare coinsurance and Part B deductible for this service effective on or after 1/1/11. Copayment/coinsurance waived; Deductible waived for HCPCS G0436 & G0437 through 9/30/16, for CPT codes 99406 & 99407 effective 10/1/16.

150.3 - Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claims Adjustment Reason Codes (CARCs), and Group Codes

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

When denying claims for counseling to prevent tobacco use services submitted without ICD-10-CM is applicable, one of the following diagnosis codes:

ICD-10 CM Code	Code Description
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17.220	Nicotine dependence, chewing tobacco, uncomplicated
F17.221	Nicotine dependence, chewing tobacco, in remission
F17.223	Nicotine dependence, chewing tobacco, with withdrawal
F17.228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17.229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
F17.290	Nicotine dependence, other tobacco product, uncomplicated
F17.291	Nicotine dependence, other tobacco product, in remission
F17.293	Nicotine dependence, other tobacco product, with withdrawal
F17.298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17.299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
T65.211A	Toxic effect of chewing tobacco, accidental (unintentional), initial encounter
T65.212A	Toxic effect of chewing tobacco, intentional self-harm, initial encounter
T65.213A	Toxic effect of chewing tobacco, assault, initial encounter
T65.214A	Toxic effect of chewing tobacco, undetermined, initial encounter
T65.221A	Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter
T65.222A	Toxic effect of tobacco cigarettes, intentional self-harm, initial encounter
T65.223A	Toxic effect of tobacco cigarettes, assault, initial encounter

T65.224A	Toxic effect of tobacco cigarettes, undetermined, initial encounter
T65.291A	Toxic effect of other tobacco and nicotine, accidental (unintentional), initial encounter
T65.292A	Toxic effect of other tobacco and nicotine, intentional self-harm, initial encounter
T65.293A	Toxic effect of other tobacco and nicotine, assault, initial encounter
T65.294A	Toxic effect of other tobacco and nicotine, undetermined, initial encounter
Z72.0	Tobacco use effective October 1, 2024
Z87.891	Personal history of nicotine dependence

or without above ICD-10-CM is applicable Part A/B MACs (A), (B), or (HHH) shall use the following messages:

CARC 16 – "Claim/service lacks information or has submission/billing error(s)."

RARC M64 - "Missing/incomplete/invalid other diagnosis"

A/B MACs (A), (B), or (HHH) shall use Group Code CO, assigning financial liability to the provider, if a claim is received with no signed ABN on file.

MSN 15.4: The information provided does not support the need for this service or item.

MSN Spanish Version: La información proporcionada no confirma la necesidad para este servicio o artículo

When denying claims for counseling to prevent tobacco use services and smoking and tobacco-use cessation counseling services that exceed a combined total of 8 sessions within a 12-month period (99406, 99407), A/B MACs (A), (B), or (HHH) shall use the following messages:

CARC 119: "Benefit maximum for this time period or occurrence has been reached."

RARC N362: "The number of days or units of service exceeds our acceptable maximum."

A/B MACs (A), (B), or (HHH) shall use Group Code PR, assigning financial liability to the beneficiary, if a claim is received with a signed ABN on file.

A/B MACs (A), (B), or (HHH) shall use Group Code CO, assigning financial liability to the provider, if a claim is received with no signed ABN on file.

MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time."

MSN Spanish Version: “Estos servicios no pueden ser pagados porque sus beneficios se han agotado.

150.4 - Common Working File (CWF)
(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

The Common Working File (CWF) shall edit for the frequency of service limitations of counseling to prevent tobacco use sessions and smoking and tobacco-use cessation counseling services (99406, 99407) rendered to a beneficiary for a combined total of 8 sessions within a 12-month period. The beneficiary may receive another 8 sessions during a second or subsequent year after 11 full months have passed since the first Medicare covered counseling session was performed. To start the count for the second or subsequent 12-month period, begin with the month after the month in which the first Medicare covered counseling session was performed and count until 11 full months have elapsed.

By entering the beneficiary’s health insurance claim number (HICN), providers have the capability to view the number of sessions a beneficiary has received for this service via inquiry through CWF.

160 - Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)
(Rev. 2432, Issued: 03-23-12, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

For services furnished on or after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) covers intensive behavioral therapy (IBT) for cardiovascular disease (CVD). See National Coverage Determinations (NCD) Manual (Pub. 100-03) §210.11 for complete coverage guidelines.

160.1 - Coding Requirements for IBT for CVD Furnished on or After November 8, 2011
(Rev. 2432, Issued: 03-23-12, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

The following is the applicable Healthcare Procedural Coding System (HCPCS) code for IBT for CVD:

G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

A/B MACs (A) and (B) shall not apply deductibles or coinsurance to claim lines containing HCPCS code G0446.

160.2 - Claims Processing Requirements for IBT for CVD Furnished on or After November 8, 2011
(Rev. 2432, Issued: 03-23-12, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

160.2.1 - Correct Place of Service (POS) Codes for IBT for CVD on Professional Claims
(Rev. 2432, Issued: 03-23-12, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

A/B MACs (B) shall pay for IBT CVD, G0446 only when services are provided at the following POS:

11- Physician's Office
22-Outpatient Hospital
49- Independent Clinic
72-Rural Health Clinic

Claims not submitted with one of the POS codes above will be denied.

The following messages shall be used when A/B MACs (B) deny professional claims for incorrect POS:

Claim Adjustment Reason Code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Remittance Advice Remark Code (RARC) N428: "Not covered when performed in this place of service."

Medicare Summary Notice (MSN) 21.25: "This service was denied because Medicare only covers this service in certain settings."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

160.2.2 - Provider Specialty Edits for IBT for CVD on Professional Claims

(Rev. 2432, Issued: 03-23-12, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

A/B MACs (B) shall pay claims for HCPCS code G0446 only when services are submitted by the following provider specialty types found on the provider's enrollment record:

01= General Practice
08 = Family Practice
11= Internal Medicine
16 = Obstetrics/Gynecology
37= Pediatric Medicine
38 = Geriatric Medicine
42= Certified Nurse Midwife
50 = Nurse Practitioner
89 = Certified Clinical Nurse Specialist
97= Physician Assistant

A/B MACs (B) shall deny claim lines for HCPCS code G0446 performed by any other provider specialty type other than those listed above.

The following messages shall be used when A/B MACs (B) deny IBT for CVD claims billed with invalid provider specialty types:

CARC 185: "The rendering provider is not eligible to perform the service billed." NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N95: "This provider type/provider specialty may not bill this service."

MSN 21.18: "This item or service is not covered when performed or ordered by this provider."

Spanish version: "Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor."

Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

160.3 - Correct Types of Bill (TOB) for IBT for CVD on Institutional Claims

(Rev. 2432, Issued: 03-23-12, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

Effective for claims with dates of service on and after November 8, 2011, the following types of bill (TOB) may be used for IBT for CVD: 13X, 71X, 77X, or 85X. All other TOB codes shall be denied.

The following messages shall be used when A/B MACs (A) deny claims for G0446 when submitted on a TOB other than those listed above:

CARC 170: Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N428: Not covered when performed in this place of service."

MSN 21.25: "This service was denied because Medicare only covers this service in certain settings."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

160.4 - Frequency Edits for IBT for CVD Claims

(Rev. 2432, Issued: 03-23-12, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

A/B MACs (A) and (B) shall allow claims for G0446 no more than once in a 12-month period.

NOTE: 11 full months must elapse following the month in which the last G0446 IBT for CVD took place.

MACs shall deny claims IBT for CVD claims that exceed one (1) visit every 12 months.

A/B MACs (A) and (B) shall allow one professional service and one facility fee claim for each visit.

The following messages shall be used when A/B MACs (A) and (B) deny IBT for CVD claims that exceed the frequency limit:

CARC 119: "Benefit maximum for this time period or occurrence has been reached."

RARC N362: "The number of days or units of service exceeds our acceptable maximum."

MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time."

Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."

Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

160.5 - Common Working File (CWF) Edits for IBT for CVD Claims

(Rev. 2432, Issued: 03-23-12, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

When applying frequency, CWF shall count 11 full months following the month of the last IBT for CVD, G0446 before allowing subsequent payment of another G0446 screening.

When applying frequency limitations to G0446, CWF shall allow both a claim for the professional service and a claim for the facility fee. CWF shall identify the following institutional claims as facility fee claims for screening services: TOB 13X, TOB85X when the revenue code is not 096X, 097X, or 098X. CWF shall identify all other claims as professional service claims for screening services.

NOTE: This does not apply to RHCs and FQHCs.

170 - Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs

(Rev. 2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

170.1 - Healthcare Common Procedure Coding System (HCPCS) Codes for Screening for STIs and HIBC to Prevent STIs

(Rev. 11759, Issued:12-21-2022, Effective:01-23-2023, Implementation:01-23-2023)

Effective for claims with dates of service on and after November 8, 2011, the claims processing instructions for payment of screening tests for STI will apply to the following HCPCS/CPT codes:

- Chlamydia:
  86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800,
  0353U- effective 10/01/22
  (used for combined chlamydia and gonorrhea testing)

- Gonorrhea:
  87590, 87591, 87850, 87800,

0353U - effective 10/01/22
(used for combined chlamydia and gonorrhea testing)

- Syphilis: 86592, 86593, 86780

- Hepatitis B: (hepatitis B surface antigen): 87340, 87341

Effective for claims with dates of service on and after November 8, 2011, implemented with the January 2, 2012, IOCE, the following HCPCS code is to be billed for HIBC to prevent STIs:

- G0445 - high-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes.

170.2 - Diagnosis Code Reporting
(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

A claim that is submitted for screening chlamydia, gonorrhea, syphilis, and/or hepatitis B shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

a. For claims for screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are <u>not</u> pregnant use the following ICD-10-CM diagnosis codes:

- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission;
- And any of

  - Z72.89 - Other problems related to lifestyle, or
  - Z72.51 - High risk heterosexual behavior, or
  - Z72.52 - High risk homosexual behavior, or
  - Z72.53 - High risk bisexual behavior (These diagnosis codes are used to indicate high/increased risk for STIs).

b. For claims for screening for syphilis in men at increased risk use the following ICD-10-CM diagnosis codes:

- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; and
- **And** any of

  - Z72.89 - Other problems related to lifestyle, or
  - Z72.51 - High risk heterosexual behavior, or
  - Z72.52 - High risk homosexual behavior, or
  - Z72.53 - High risk bisexual behavior (These diagnosis codes are used to indicate high/increased risk for STIs).

c. For claims for screening for chlamydia and gonorrhea in pregnant women at increased risk for STIs use the following ICD-10-CM diagnosis codes, if applicable:

- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; **and** one of:

    - Z72.89 - Other problems related to lifestyle, or
    - Z72.51 - High risk heterosexual behavior, or
    - Z72.52 - High risk homosexual behavior, or
    - Z72.53 - High risk bisexual behavior (These diagnosis codes are used to indicate high/increased risk for STIs).

and also one of the following.

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

d. For claims for screening for syphilis in pregnant women use the following ICD-10-CM diagnosis codes:

- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; and one of

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

e. For claims for screening for syphilis in pregnant women at increased risk for STIs use the following ICD-10-CM diagnosis codes:

- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; **and** any of:

  - Z72.89 - Other problems related to lifestyle, or
  - Z72.51 - High risk heterosexual behavior, or
  - Z72.52 - High risk homosexual behavior, or
  - Z72.53 - High risk bisexual behavior (These diagnosis codes are used to indicate high/increased risk for STIs).

  and also one of the following:

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester

Code	Description
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

f. For claims for screening for hepatitis B in pregnant women use the following ICD-10-CM diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases, **and** any of
- Z34.00 - Encounter for supervision of normal first pregnancy, unspecified trimester, or
- Z34.80 - Encounter for supervision of other normal pregnancy, unspecified trimester, or
- Z34.90 - Encounter for supervision of normal pregnancy, unspecified, unspecified trimester, or
- O09.90 - Supervision of high risk pregnancy, unspecified, unspecified trimester.

g. For claims for screening for hepatitis B in pregnant women at increased risk for STIs use the following ICD-10 -CM diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases, and
- Z72.89 - Other problems related to lifestyle, **and**
- any of
  - Z72.51 - High risk heterosexual behavior, or
  - Z72.52 - High risk homosexual behavior, or
  - Z72.53 - High risk bisexual behavior;
- **and** also one of the following:

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester

Code	Description
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

170.3 - Billing Requirements

(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

Effective for dates of service November 8, 2011, and later, A/B MACs (A) and (B) shall recognize HCPCS code G0445 for HIBC. Medicare shall cover up to two occurrences of G0445 when billed for HIBC to prevent STIs. A claim that is submitted with HCPCS code G0445 for HIBC shall be submitted with ICD-10-CM diagnosis code Z72.89.

A/B MACs (A) and (B) shall pay for screening for chlamydia, gonorrhea, and syphilis (as indicated by the presence of ICD-10 is applicable, ICD-10-CM diagnosis code Z11.3; and/or hepatitis B (as indicated by the presence of ICD-10-CM diagnosis code Z11.59 as follows:

- One annual occurrence of screening for chlamydia, gonorrhea, and syphilis (i.e., 1 per 12-month period) in women at increased risk who are not pregnant,
- One annual occurrence of screening for syphilis (i.e., 1 per 12-month period) in men at increased risk,
- Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening,
- One occurrence per pregnancy of screening for syphilis in pregnant women,
- Up to an additional two occurrences per pregnancy of screening for syphilis in pregnant women if the beneficiary is at continued increased risk for STIs,
- One occurrence per pregnancy of screening for hepatitis B in pregnant women, and,
- One additional occurrence per pregnancy of screening for hepatitis B in pregnant women who are at continued increased risk for STIs.

170.4 - Types of Bill (TOBs) and Revenue Codes

(Rev. 2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

The applicable types of bill (TOBs) for HIBC screening, HCPCS code G0445, are: 13X, 71X, 77X, and 85X.

On institutional claims, TOBs 71X and 77X, use revenue code 052X to ensure coinsurance and deductible are not applied.

Critical access hospitals (CAHs) electing the optional method of payment for outpatient services report this service under revenue codes 096X, 097X, or 098X.

170.4.1 - Payment Method

(Rev. 2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

Payment for HIBC is based on the all-inclusive payment rate for rural health clinics (TOBs 71X) and federally qualified health centers (TOB 77X). Hospital outpatient departments (TOB 13X) are paid based on the outpatient prospective payment system and CAHs (TOB 85X) are paid based on reasonable cost. CAHs electing the optional method of payment for outpatient services are paid based on 115% of the lesser of the Medicare Physician Fee Schedule (MPFS) amount or submitted charge.

Effective for dates of service on and after November 8, 2011, deductible and coinsurance do not apply to claim lines with G0445.

HCPCS code G0445 may be paid on the same date of service as an annual wellness visit, evaluation and management (E&M) code, or during the global billing period for obstetrical care, but only one G0445 may be paid on any one date of service. If billed on the same date of service with an E&M code, the E&M code should have a distinct diagnosis code other than the diagnosis code used to indicate high/increased risk for STIs for the G0445 service. An E&M code should not be billed when the sole reason for the visit is HIBC to prevent STIs.

For Medicare Part B physician and non-practitioner claims, payment for HIBC to prevent STIs is based on the MPFS amount for G0445.

170.5 - Specialty Codes and Place of Service (POS)

(Rev. 2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

Medicare provides coverage for screening for chlamydia, gonorrhea, syphilis, and/or hepatitis B and HIBC to prevent STIs only when ordered by a primary care practitioner (physician or non-physician) with any of the following specialty codes:

- 01 - General Practice
- 08 - Family Practice
- 11 - Internal Medicine
- 16 - Obstetrics/Gynecology
- 37 - Pediatric Medicine
- 38 - Geriatric Medicine
- 42 - Certified Nurse Midwife
- 50 - Nurse Practitioner
- 89 - Certified Clinical Nurse Specialist
- 97 - Physician Assistant

Medicare provides coverage for HIBC to prevent STIs only when provided by a primary care practitioner (physician or non-physician) with any of the specialty codes identified above.

Medicare provides coverage for HIBC to prevent STIs only when the POS billed is 11, 22, 49, or 71.

180 - Alcohol Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

(Rev. 2433, Issued: 03-26-12, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

The United States Preventive Services Task Force (USPSTF) defines alcohol misuse as risky, hazardous, or harmful drinking which places an individual at risk for future problems with alcohol consumption. In the general adult population, alcohol consumption becomes risky or hazardous when consuming:

- Greater than 7 drinks per week or greater than 3drinks per occasion for women and persons greater than 65 years old.

- Greater than 14 drinks per week or greater than 4 drinks per occasion for men 65 years old and younger.

180.1 - Policy

(Rev. 2433, Issued: 03-26-12, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

Claims with dates of service on and after October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual alcohol misuse screening (HCPCS code G0442) consisting of 1 screening session, and for those that screen positive, up to 4 brief, face-to-face behavioral counseling sessions (HCPCS code G0443) per 12-month period for Medicare beneficiaries, including pregnant women.

Medicare beneficiaries that may be identified as having a need for behavioral counseling sessions include those:

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and,

- Who are competent and alert at the time that counseling is provided; and,

- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Once a Medicare beneficiary has agreed to behavioral counseling sessions, the counseling sessions are to be completed based on the 5As approach adopted by the United States Preventive Services Task Force (USPSTF.) The steps to the 5As approach are listed below.

1. **Assess**: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.

2. **Advise**: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.

3. **Agree**: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.

4. **Assist**: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.

5. **Arrange**: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

180.2 - Institutional Billing Requirements

(Rev. 2433, Issued: 03-26-12, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

For claims with dates of service on and after October 14, 2011, Medicare will allow coverage for annual alcohol misuse screening, 15 minutes, G0442, and brief, face-to-face behavioral counseling for alcohol misuse, 15 minutes, G0443 for:

- Rural Health Clinics (RHCs) - type of bill (TOB) 71X only - based on the all-inclusive payment rate
- Federally Qualified Health Centers (FQHCs) - TOB 77X only - based on the all-inclusive payment rate
- Outpatient hospitals - TOB 13X - based on Outpatient Prospective Payment System (OPPS)
- Critical Access Hospitals (CAHs) - TOB 85X - based on reasonable cost
- CAH Method II - TOB 85X - based on 115% of the lesser of the Medicare Physician Fee Schedule (MPFS) amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

For RHCs and FQHCs the alcohol screening/counseling is not separately payable with another face-to-face encounter on the same day. This does not apply to the Initial Preventive Physical Examination (IPPE), unrelated services denoted with modifier 59, and 77X claims containing Diabetes Self Management Training (DSMT) and Medical Nutrition Therapy (MNT)services. DSMT and MNT apply to FQHCs only. However, the screening/counseling sessions alone when rendered as a face-to-face visit with a core practitioner do constitute an encounter and is paid based on the all-inclusive payment rate.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

Claims submitted with alcohol misuse screening and behavioral counseling HCPCS codes G0442 and G0443 on a TOB other than 13X, 71X, 77X, and 85X will be denied.

Effective October 14, 2011, deductible and co-insurance should not be applied for line items on claims billed for alcohol misuse screening G0442 and behavioral counseling for alcohol misuse G0443.

180.3 - Professional Billing Requirements

(Rev. 2433, Issued: 03-26-12, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

For claims with dates of service on and after October 14, 2011, CMS will allow coverage for annual alcohol misuse screening, 15 minutes, G0442, and behavioral counseling for alcohol misuse, 15 minutes, G0443, only when services are submitted by the following provider specialties found on the provider's enrollment record:

01 - General Practice
08 - Family Practice
11 - Internal Medicine
16 - Obstetrics/Gynecology
37 - Pediatric Medicine
38 - Geriatric Medicine
42 - Certified Nurse-Midwife
50 - Nurse Practitioner
89 - Certified Clinical Nurse Specialist
97 - Physician Assistant

Any claims that are not submitted from one of the provider specialty types noted above will be denied.

For claims with dates of service on and after October 14, 2011, CMS will allow coverage for annual alcohol misuse screening, 15 minutes, G0442, and behavioral counseling for alcohol misuse, 15 minutes, G0443, only when submitted with one of the following place of service (POS) codes:

11 - Physician's Office
22 - Outpatient Hospital
49 - Independent Clinic
71 - State or local public health clinic or

Any claims that are not submitted with one of the POS codes noted above will be denied.

The alcohol screening/counseling services are payable with another encounter/visit on the same day. This does not apply for IPPE.

180.4 - Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Group Codes, and Medicare Summary Notice Messages

(Rev. 2433, Issued: 03-26-12, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

A/B MACs (A) and (B) shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for alcohol misuse screening and alcohol misuse behavioral counseling sessions:

- For RHC and FQHC claims that contain screening for alcohol misuse HCPCS code G0442 and alcohol misuse counseling HCPCS code G0443 with another encounter/visit with the same line item date of service, use group code CO and reason code:

    - Claim Adjustment Reason Code (CARC) 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present

- Denying claims containing HCPCS code G0442 and HCPCS code G0443 submitted on a TOB other than 13X, 71X, 77X, and 85X:

    - Claim Adjustment Reason Code (CARC) 5 - The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present

    - Remittance Advice Remark Code (RARC) M77 - Missing/incomplete/invalid place of service

    - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

    - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

- Denying claims that contains more than one alcohol misuse behavioral counseling session G0443 on the same date of service:

    - Medicare Summary Notice (MSN) 15.6 - The information provided does not support the need for this many services or items within this period of time.

    - Claim Adjustment Reason Code (CARC) 151 - Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

    - Remittance Advice Remark Code (RARC) M86 - Service denied because payment already made for same/similar procedure within set time frame.

    - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

    - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

- Denying claims that are not submitted from the appropriate provider specialties:

    - Medicare Summary Notice (MSN) 21.18 - This item or service is not covered when performed or ordered by this provider.

    - Claim Adjustment Reason Code (CARC) 185 - The rendering provider is not eligible to perform the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

    - Remittance Advice Remark Code (RARC) N95 - This provider type/provider specialty may not bill this service.

    - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

    - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

- Denying claims without the appropriate POS code:

    - Medicare Summary Notice (MSN) 21.25 - This service was denied because Medicare only covers this service in certain settings.

    - Claim Adjustment Reason Code (CARC) 58 - Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.

    - Remittance Advice Remark Code (RARC) N428 - Not covered when performed in this place of service.

    - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

    - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

- Denying claims for alcohol misuse screening HCPCS code G0442 more than once in a 12-month period, and denying alcohol misuse counseling sessions HCPCS code G0443 more than four times in the same 12-month period:

    - Medicare Summary Notice (MSN) 20.5 - These services cannot be paid because your benefits are exhausted at this time.

    - Claim Adjustment Reason Code (CARC) 119 - Benefit maximum for this time period or occurrence has been reached.

    - Remittance Advice Remark Code (RARC) N362 - The number of Days or Units of service exceeds our acceptable maximum.

    - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

    - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

180.5 - CWF Requirements

(Rev. 2433, Issued: 03-26-12, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

When applying frequency, CWF shall count 11 full months following the month of the last alcohol misuse screening visit, G0442, before allowing subsequent payment of another G0442 screening. Additionally, CWF shall create an edit to allow alcohol misuse brief behavioral counseling, HCPCS G0443, no more than 4 times in a 12-month period and make this edit overridable. CWF shall also count four alcohol misuse counseling sessions HCPCS G0443 in the same 12-month period used for G0442 counting from the date the G0442 screening session was billed.

When applying frequency limitations to G0442 screening on the same date of service as G0443 counseling, CWF shall allow both a claim for the professional service and a claim for a facility fee. CWF shall identify

the following institutional claims as facility fee claims for screening services: TOB 13X, TOB 85X when the revenue code is not 096X, 097X, or 098X. CWF shall identify all other claims as professional service claims for screening services. NOTE: This does not apply to RHCs and FQHCs.

190 - Screening for Depression in Adults (Effective October 14, 2011)

(Rev. 2431, Issued: 03-23-12, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

A. Coverage Requirements

Effective October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual screening up to 15 minutes for Medicare beneficiaries in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. Various screening tools are available for screening for depression. CMS does not identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting. Screening for depression is non-covered when performed more than one time in a 12-month period. The Medicare coinsurance and Part B deductible are waived for this preventive service.

Additional information on this National Coverage Determination (NCD) for Screening for Depression in Adults can be found in Publication 100-03, NCD Manual, Section 210.9.

190.1 - A/B MAC (B) Billing Requirements

(Rev. 2431, Issued: 03-23-12, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

Effective October 14, 2011, A/B MACs (B) shall recognize new HCPCS G0444, annual depression screening, 15 minutes.

190.2 - Frequency

(Rev. 2431, Issued: 03-23-12, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

A/B MACs (B) shall pay for annual depression screening, G0444, no more than once in a 12-month period.

NOTE: 11 full months must elapse following the month in which the last annual depression screening took place.

190.3 - Place of Service (POS)

(Rev. 12763, Issued: 08-01-24; Effective: 01-01-25; Implementation: 01-06-25)

A/B MACs (B) shall pay for annual depression screening claims, G0444, only when services are provided at the following places of service (POS):

02 - Telehealth Provided Other than in Patient’s Home
10 - Telehealth Provided in Patient's Home
11 - Office
19 - Off Campus-Outpatient Hospital
22 - On Campus-Outpatient Hospital
49 - Independent Clinic
71 - State or Local Public Health Clinic

190.4 - Common Working File (CWF) Edits

(Rev. 2431, Issued: 03-23-12, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

CWF shall count 11 full months from the month of the prior annual depression screening, G0444, before allowing subsequent payment.

190.5 - Professional Billing Requirements

(Rev. 12763, Issued: 08-01-24; Effective: 01-01-25; Implementation: 01-06-25)

A/B MACs (B) shall use the following claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare Summary Notice (MSN) messages when denying payment for G0444 when reported more than once in a 12-month period.

- o CARC 119 - “Benefit maximum for this time period or occurrence has been reached.”

- o RARC N362 - “The number of days or units of service exceeds our acceptable maximum.”

- o MSN 20.5 - “These services cannot be paid because your benefits are exhausted at this time.”

  Spanish Version - “Estos servicios no pueden ser pagados porque sus beneficios se han agotado.”

- o Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

- o Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

A/B MACs (B) shall use the following CARCs, RARCs, group codes, or MSNs messages when denying payment for G0444 and POS codes other than those identified in section 190.3.

- o CARC 96 - “Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

- o RARC N428 - “Not covered when performed in this place of service.”

- o MSN 21.25 - “This service was denied because Medicare only covers this service in certain settings.”

  Spanish Version - “El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

- o Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

- o Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

190.6 - Institutional Billing Requirements

(Rev. 2431, Issued: 03-23-12, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

For claims with dates of service on and after October 14, 2011, Medicare will allow coverage for annual screening depression in adults, HCPCS G0444 for:

- Rural Health Clinics (RHCs) type of bill (TOB) 71X only - based on the all-inclusive payment rate.
- Federally Qualified Health Centers (FQHCs) TOB 77X only - based on the all-inclusive payment rate.
- Outpatient hospitals - Based on Outpatient Prospective Payment System (OPPS) TOB 13X - based on reasonable cost.
- Critical Access Hospitals (CAHs) TOB 85X - based on reasonable cost.
- CAH Method II with revenue codes 096x, 097x, or 098x only - based on 115% of the lesser of the actual charge or the MPFS.

For RHCs and FQHCs, annual screening for depression in adults is not separately payable with another face-to-face encounter on the same day. This does not apply to the Initial Preventive Physical Examination (IPPE), unrelated services denoted with modifier 59, and 77X claims containing Diabetes Self-Management Training (DSMT) and/or Medical Nutrition Therapy (MNT) services. DSMT and MNT apply to FQHC's only. However, annual screening depression by itself, when rendered as a face-to-face visit with a core practitioner, does constitute an encounter and is paid based on the all-inclusive payment rate.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

Claims submitted with the annual screening depression HCPCS G0444 code on a TOB other than 13X, 71X, 77X, and 85X will be denied.

Effective for dates of service on and after October 14, 2011, deductible and coinsurance shall not be applied for claims billed for annual depression screening in adults with HCPCS G0444 at the line-level.

190.7 - CARCs, RARCs, Group Codes, and MSN Messages

(Rev. 2431, Issued: 03-23-12, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

A/B MACs (A) and (B) shall use the appropriate CARC, RARC, group codes, or MSN messages when denying payment for annual depression screening in adults:

- For RHCs and FQHCs when screening for depression, HCPCS code G0444, with another encounter/visit with the same line-item date of service, use group code CO and :
    - CARC 97 - "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present."

- Denying claims containing HCPCS code G0444, submitted on a TOB other than 13X, 71X, 77X, and 85X:

    - MSN 21.25 - "This service was denied because Medicare only covers this service in certain settings."

    - CARC 170 - "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

    - RARC N428 - "Not covered when performed in this place of service."

    - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

    - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

- Denying claims containing HCPCS code G0444, depression screening in adults, more than once in a 12-month period:

    - MSN 20.5 - "These services cannot be paid because your benefits are exhausted at this time."

    - CARC 119 - "Benefit maximum for this period or occurrence has been reached."

    - RARC N362 - "The number of days or units of service exceeds our acceptable maximum."

    - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

    - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

200 - Intensive Behavioral Therapy for Obesity (Effective November 29, 2011)

(Rev. 2421, Issued: 03-07-12, Effective: 11-29-11, Implementation: 03-06-12, for non-shared system edits, 07-02-12 for shared system edits, CWF provider screen .HICR, and MCSDT changes)

The United States Preventive Services Task Force (USPSTF) found good evidence that body mass index (BMI) is a reliable and valid indicator for identifying adults at increased risk for mortality and morbidity due to overweight and obesity. It also good evidence that high intensity counseling combined with behavioral interventions in obese adults (as defined by a BMI $\geq$30 kg/m^2) produces modest, sustained weight loss.

200.1 - Policy

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

For services furnished on or after November 29, 2011, Medicare will cover Intensive Behavioral Therapy for Obesity. Medicare beneficiaries with obesity (BMI $\geq$30 kg/m^2) who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting are eligible for:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs.) weight loss requirement during the first 6 months as discussed below.

The counseling sessions are to be completed based on the 5As approach adopted by the United States Preventive Services Task Force (USPSTF.) The steps to the 5As approach are listed below:

1. **Assess**: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.

2. **Advise**: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.

3. **Agree**: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.

4. **Assist**: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.

5. **Arrange**: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Medicare will cover Face-to-Face Behavioral Counseling for Obesity, 15 minutes (G0447), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9-CM codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), up to 22 sessions in a 12-month period for Medicare beneficiaries. The Medicare coinsurance and Part B deductible are waived for this preventive service.

NOTE: Effective for claims with dates of service on or after January 1, 2015, codes G0473 and G0447 can be billed for a total of no more than 22 sessions in a 12-month period.

A/B MACs (A) and (B) shall note the appropriate ICD-10-CM code(s) that are listed below for future implementation. A/B MACs (A) and (B) shall track the ICD-10-CM codes and ensure that the updated edit is turned on when ICD-10 is implemented.

ICD-10-CM	Description
Z68.30	BMI 30.0-30.9, adult
Z68.31	BMI 31.0-31.9, adult
Z68.32	BMI 32.0-32.9, adult
Z68.33	BMI 33.0-33.9, adult
Z68.34	BMI 34.0-34.9, adult
Z68.35	BMI 35.0-35.9, adult
Z68.36	BMI 36.0-36.9, adult
Z68.37	BMI 37.0-37.9, adult
Z68.38	BMI 38.0-38.9, adult
Z68.39	BMI 39.0-39.9, adult

Z68.41	BMI 40.0-44.9, adult
Z68.42	BMI 45.0-49.9, adult
Z68.43	BMI 50.0-59.9, adult
Z68.44	BMI 60.0-69.9, adult
Z68.45	BMI 70 or greater, adult

See Pub. 100-03, Medicare National Coverage Determinations Manual, §210.12 for complete coverage guidelines.

200.2 - Institutional Billing Requirements

(Rev. 3232, Issued: 04-03-15, Effective: 01-01-15, Implementation: 01-05-15)

Effective for claims with dates of service on and after November 29, 2011, providers may use the following types of bill (TOB) when submitting HCPCS code G0447: 13x, 71X, 77X, or 85X. Service line items on other TOBs shall be denied.

Effective for claims with dates of service on and after January 1, 2015, providers may use the following types of bill (TOB) when submitting HCPCS code G0473: 13x or 85X. Service line items on other TOBs shall be denied.

The service shall be paid on the basis shown below:

- Outpatient hospitals - TOB 13X - based on Outpatient Prospective Payment System (OPPS)
- Critical Access Hospitals (CAHs) - TOB 85X - based on reasonable cost
- CAH Method II - TOB 85X - based on 115% of the lesser of the Medicare Physician Fee Schedule (MPFS) amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

NOTE: For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

200.3 - Professional Billing Requirements

(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, (G0447), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9 codes

for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), only when services are submitted by the following provider specialties found on the provider's enrollment record:

01 - General Practice
08 - Family Practice
11 - Internal Medicine
16 - Obstetrics/Gynecology
37 - Pediatric Medicine
38 - Geriatric Medicine
50 - Nurse Practitioner
89 - Certified Clinical Nurse Specialist
97 - Physician Assistant

Any claims that are not submitted from one of the provider specialty types noted above will be denied.

CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, (G0447), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), only when submitted with one of the following place of service (POS) codes:

11 - Physician's Office
19 - Off Campus-Outpatient Hospital
22 - On Campus-Outpatient Hospital
49 - Independent Clinic
71 - State or Local Public Health Clinic

Any claims that are not submitted with one of the POS codes noted above will be denied.

NOTE: HCPCS Code G0447 is effective November 29, 2011. HCPCS Code G0473 is effective January 1, 2015.

200.4 - Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

A/B MACs (A) and (B) shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for obesity counseling sessions:

- Denying services submitted on a TOB other than 13X and 85X:

  CARC 171 - Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N428 - Not covered when performed in this place of service.

  MSN 16.2 - This service cannot be paid when provided in this location/facility.

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying services for obesity counseling sessions HCPCS code G0473 or G0447 with 1 of the ICD-9-CM codes (V85.30-V85.39 or V85.41-V85.45) or with one of the ICD-10-CM codes (Z68.30-Z68.39 or Z68.41-Z68.45) when billed for a total of more than 22 sessions in the same 12-month period:

  CARC 119 - Benefit maximum for this time period or occurrence has been reached.

  RARC N362 - The number of days or units of service exceeds our acceptable maximum.

  MSN 20.5 - These services cannot be paid because your benefits are exhausted at this time.

  Spanish Version: “Estos servicios no pueden ser pagados porque sus beneficios se han agotado.”

  Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

  Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines for obesity counseling sessions HCPCS code G0473 or G0447 without 1 of the appropriate ICD-9-CM codes (V85.30-V85.39 or V85.41-V85.45) or 1 of the ICD-10-CM codes (Z68.30-Z68.39 or Z68.41-Z68.45):

  CARC 167 - “This (these) diagnosis(es) is (are) not covered. Note: Refer to the ASC X12 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

  RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

  MSN 14.9 - “Medicare cannot pay for this service for the diagnosis shown on the claim.”

  Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

  Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines without the appropriate POS code:

CARC 5 - The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC M77 - Missing/incomplete/invalid place of service.

MSN 21.25 - This service was denied because Medicare only covers this service in certain settings.

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines that are not submitted from the appropriate provider specialties:

CARC 8 - "The procedure code is inconsistent with the provider type/specialty (taxonomy). NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

RARC N95 - "This provider type/provider specialty may not bill this service."

MSN 21.18 - "This item or service is not covered when performed or ordered by this provider."

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

200.5 - Common Working File (CWF) Edits

(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

When applying frequency, CWF shall count 22 counseling sessions of any of G0473 and/or G0447 (for a total of no more than 22 sessions in the same 12-month period) along with 1 ICD-9-CM code from V85.30-V85.39 or V85.41-V85.45 in a 12-month period, or if ICD-10 is applicable with 1 ICD-10-CM code from Z68.30-Z68.39 or Z68.41-Z68.45. When applying frequency limitations to G0473 or G0447 counseling CWF shall allow both a claim for the professional service and a claim for a facility fee. CWF shall identify the following institutional claims as facility fee claims for this service: TOB 13X, TOB 85X when the revenue code is not 096X, 097X, or 098X. CWF shall identify all other claims as professional service claims.

210 - Screening for Hepatitis C Virus (HCV)

(Rev. 3215, Issued: 03-11-15, Effective: 06-02-14, Implementation: 01-05-15 - For non-shared MAC edits and CWF analysis; 04-06-15 - For remaining shared systems edits)

Effective for services furnished on or after June 2, 2014, Medicare covers screening for hepatitis C Virus (HCV) with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act regulations, when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

A. Frequency

1. A single, one-time HCV screening test is covered for adults who are not considered high risk as defined below, but who were born from 1945 through 1965. Those persons born prior to 1945 or after 1965 without high risk factors are not eligible for this benefit.

2. An initial screening for HCV is covered for adults at high risk for HCV infection regardless of birth year. "High risk" is defined as persons with a current or past history of illicit injection drug use and persons who have a history of receiving a blood transfusion prior to 1992.

3. Repeat HCV screening for a sub-set of high risk persons regardless of birth year is covered annually only for persons who have had continued illicit injection drug use since the prior negative HCV screening test.

NOTE: Annual means a full 11 months must elapse following the month in which the previous negative HCV screening took place.

B. Determination of High Risk for Hepatitis C Disease

The determination of "high risk for HCV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit, and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

NOTE: See Pub. 100-03, Medicare National Coverage Determinations (NCD) Manual, §210.13 for complete coverage guidelines.

NOTE: Beneficiary coinsurance and deductibles do not apply to claim lines containing HCPCS G0472, hepatitis C antibody screening for individual at high risk and other covered indication(s).

NOTE: A/B MACs (B) shall contractor-price HCV screening claims, HCPCS G0472, with dates of service June 2, 2014 through December 31, 2015.

210.1 – Institutional Billing Requirements

(Rev. 3393, Issued: 11-05-15, Effective: 06-02-14, Implementation: 04-04-16)

Effective for claims with dates of service on and after June 2, 2014, providers may use the following types of bill (TOBs) when submitting claims for screening for HCV screening, HCPCS G0472: 13X, 14X, and 85X. Service line-items on other TOBs shall be denied.

The service shall be paid on the basis shown below:

- Outpatient hospitals – TOB 13X - based on Outpatient Prospective Payment System (OPPS)
- Non-patient laboratory specimen – TOB 14X – based on laboratory fee schedule
- Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost

NOTE: For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

210.2 - Professional Billing Requirements

(Rev. 3215, Issued: 03-11-15, Effective: 06-02-14, Implementation: 01-05-15 - For non-shared MAC edits and CWF analysis; 04-06-15 - For remaining shared systems edits)

For claims with dates of service on or after June 2, 2014, Medicare will allow coverage for HCV screening, HCPCS G0472, only when services are ordered by the following provider specialties found on the provider's enrollment record:

01 - General Practice
08 - Family Practice
11 - Internal Medicine
16 - Obstetrics/Gynecology
37 - Pediatric Medicine
38 - Geriatric Medicine
42 - Certified Nurse Midwife
50 - Nurse Practitioner
89 - Certified Clinical Nurse Specialist
97 - Physician Assistant

HCV screening services ordered by providers other than the specialty types noted above will be denied.

For claims with dates of service on or after June 2, 2014, Medicare will allow coverage for HCV screening, HCPCS G0472, only when submitted with one of the following place of service (POS) codes:

11 - Physician's Office
22 - Outpatient Hospital
49 - Independent Clinic
71 - State or Local Public Health Clinic
81 - Independent Laboratory

HCV screening claims submitted without one of the POS codes noted above will be denied.

210.3 – Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

Contractors shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for HCV screening, HCPCS G0472:

- Denying services submitted on a TOB other than 13X, 14X, or 85X:

  CARC 170 - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N95 – This provider type/provider specialty may not bill this service.

  MSN 21.25: This service was denied because Medicare only covers this service in certain settings.

Spanish Version: “El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

Denying services where previous HCV screening, HCPCS G0472, is paid in history for claims with dates of service on and after June 2, 2014, and the patient is not deemed high risk by the presence of ICD-10 diagnosis code Z72.89, other problems related to lifestyle, and ICD-10 diagnosis code F19.20, other psychoactive substance dependence, uncomplicated:

CARC 119 – Benefit maximum for this time period or occurrence has been reached.

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

MSN 15.20 – The following policies NCD210.13 were used when we made this decision.

Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

MSN 15.19 - Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

NOTE: This edit shall be overridable.

Denying services for HCV screening, HCPCS G0472, for beneficiaries at high risk who have had continued illicit drug use since the prior negative screening test, when claims are not submitted with ICD-10 diagnosis code Z72.89, and ICD-10 diagnosis code F19.20, and/or 11 full months have not passed since the last negative HCV screening test:

CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

MSN 15.20: "The following policies [insert LMRP/LCD ID #(s) and NCD #(s)] were used when we made this decision.

Spanish Version - Las siguientes políticas [añadir los #s de LMRP/LCD, por sus siglas en inglés y los #s de NCD, por sus siglas en inglés] fueron utilizadas cuando se tomó esta decisión.

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

NOTE: This edit shall be overridable.

- Denying services for HCV screening, G0472, for beneficiaries who do not meet the definition of high risk, but who were born from 1945 through 1965, when claims are submitted more than once in a lifetime:

  CARC 119: "Benefit maximum for this time period or occurrence has been reached."

  RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

  MSN 15.20 – The following policies NCD210.13 were used when we made this decision.

  Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

  MSN 15.19 - Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD.

  Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

  NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

  Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

  NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

NOTE: This edit shall be overridable.

- Denying claim lines for HCV screening, G0472, without the appropriate POS code:

  CARC 171 – Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N428 - Not covered when performed in certain settings.

  MSN 21.25 - This service was denied because Medicare only covers this service in certain settings.

  Spanish Version: “El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

  Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

- Denying claim lines for HCV screening, G0472, that are not submitted from the appropriate provider specialties:

  CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N574 – Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.

MSN 21.18 - This item or service is not covered when performed or ordered by this provider.

Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

- Denying claim lines for HCV screening, HCPCS G0472, if beneficiary born prior to 1945 and after 1965 who are not at high risk (absence of ICD-10 diagnosis code Z72.89 or F19.20 or Z11.59:

  CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

MSN 15.19 - Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20 – The following policies NCD210.13 were used when we made this decision.

Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

210.4 - Common Working File (CWF) Edits

(Rev. 11021; Issued: 10-01-21; Effective: 10-29-21; Implementation: 10-29-21)

The common working file (CWF) shall apply the following frequency limitations to HCV screening, HCPCS G0472:

One initial HCV screening, HCPCS G0472, for beneficiaries at high risk, when claims are submitted with ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented),

Annual HCV screening, HCPCS G0472, when claims are submitted with ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented), and ICD-9 diagnosis code 304.91/ICD-10 diagnosis code F19.20 (once ICD-10 is implemented),

Once in a lifetime HCV screening, HCPCS G0472, for beneficiaries who are not high risk who were born from 1945 through 1965.

NOTE: These edits shall be overridable.

NOTE: HCV screening, HCPCS G0472 is not a covered service for beneficiaries born prior to 1945 and after 1965 who are not at high risk (absence of ICD-10 diagnosis code Z72.89 and/or F19.20 and/or Z11.59 ICD-10 diagnosis code.

220 - Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

(Rev. 3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

Effective for services furnished on or after February 5, 2015, Medicare covers a lung cancer screening counseling and shared decision making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT) if all the eligibility requirements listed in the national coverage determination (NCD) are met.

See Pub.100-03, Medicare NCD Manual, Chapter 1, Section 210.14, for complete coverage requirements.

220.1 - Health Care Common Procedure Coding System (HCPCS) Codes
(Rev. 3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

Effective for claims with dates of service on and after February 5, 2015, the following codes are used for lung cancer screening with LDCT services:

G0296 - Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)

G0297 - Low dose CT scan (LDCT) for lung cancer screening

220.2 - Institutional Billing Requirements
(Rev. 3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

Effective for claims with dates of service on and after February 5, 2015, providers may use the following types of bill (TOBs) when submitting claims for LDCT lung cancer screening, HCPCS codes G0296 and G0297: 12X, 13X, 22X, 23X, and 85X.

Effective for claims with dates of service on and after February 5, 2015, providers may also use the following TOBs when submitting claims for LDCT lung cancer screening, HCPCS code G0296: 71X, 77X, and 85X with revenue code 096X, 097X, and 098X.

The service shall be paid on the basis shown below:

- Outpatient hospital departments - TOBs 12X and 13X - based on Outpatient Prospective Payment System (OPPS),
- Skilled nursing facilities (SNFs) - TOBs 22X and 23X - based on the Medicare Physician Fee Schedule (MPFS),
- -Critical Access Hospitals (CAHs) - TOB 85X - based on reasonable cost,
- -CAH Method II - TOB 85X with revenue code 096X, 097X, or 098X based on the lesser of the actual charge or the MPFS (115% of the lesser of the fee schedule amount and submitted charge) for HCPCS code G0296 only,
- -Rural Health Clinics (RHCs) - TOB 71X - based on the all-inclusive rate for HCPCS G0296 only, and
- -Federally Qualified Health Centers (FQHCs) - TOB 77X - based on the prospective payment systems (PPS) rate for HCPCS G0296 only.

NOTE: For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered and performed by eligible Medicare providers for these services that meet the eligibility and coverage requirements of this NCD. See Pub.100-03, Medicare NCD Manual, Chapter 1, Section 210.14, for complete coverage requirements.

220.3 - Deductible and Coinsurance

(Rev. 3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

There is no deductible and no coinsurance for HCPCS codes G0296 and G0297 claim lines.

220.4 – Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

(Rev11388, Issued:04-29, 22; (Effective:02-10-22; Implementation:10-03-22)

Contractors shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for LDCT lung cancer screening services, HCPCS codes G0296 and 71271:

- Denying **services** submitted on a TOB other than 12X, 13X, 22X, 23X, 71X, 77X, or 85X:

  CARC 170 - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N95 – This provider type/provider specialty may not bill this service.

  MSN 21.25: This service was denied because Medicare only covers this service in certain settings.

  Spanish Version: “El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

  Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: For modifier GZ, use CARC 50 and MSN 8.81.
  NOTE: Effective December 31, 2020, HCPCS code G0297 is end-dated and replaced with 71271.

- Denying services for HCPCS G0296 for TOBs 71X and 77X when G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71X TOBs), for claims with dates of service on and after February 5, 2015:

  CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

  MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the ‘You May Be Billed’ column.

  NOTE: 77X TOBs will be processed through the Integrated Outpatient Code Editor under the current process.

  Group Code CO assigning financial liability to the provider.

- Denying services where a previous HCPCS G0297 (effective January 1, 2021, G0297 is replaced with 71271), is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening), for claims with dates of service on and after February 5, 2015:

  CARC 119 – Benefit maximum for this time period or occurrence has been reached.

  RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

  MSN 15.20: "The following policy was used when we made this decision: NCD 210.14."

  Spanish Version – "Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 210.14."

  Contractors processing institutional claims shall use the following MSN message in addition to MSN 15.20:

  MSN 15.19 - Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD.

  Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

  NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

  Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines for HCPCS G0296 and 71271 because the beneficiary is not between the ages of 50 and 77 (55 and 77 for DOS prior to February 10, 2022) at the time the service was rendered:

  NOTE: Effective December 31, 2020 HCPCS code G0297 is end-dated and replaced with 71271.

  CARC 6: "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

  MSN 15.20: "The following policy was used when we made this decision: NCD 210.14.

  Spanish Version – "Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 210.14."

Contractors processing institutional claims shall use the following MSN message in addition to MSN 15.20:

MSN 15.19 - Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

Group Code: CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines for HCPCS G0296 and 71271 because the claim line was not billed with ICD-10 codes Z87.891(personal history of tobacco use/personal history of nicotine dependence), F17.210 (Nicotine dependence, cigarettes, uncomplicated), F17.211 (Nicotine dependence, cigarettes, in remission), F17.213 (Nicotine dependence, cigarettes, with withdrawal), F17.218 (Nicotine dependence, cigarettes, with other nicotine-induced disorders), or F17.219 (Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders), effective with dates of service on or after October 1, 2015.

NOTE: Effective December 31, 2020, HCPCS code G0297 is end-dated and replaced with 71271. CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

MSN 15.20 – The following policy was used when we made this decision: NCD 210.14.

Spanish Version – “Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 210.14.”

Contractors processing institutional claims shall use the following MSN message in addition to MSN 15.20:

MSN 15.19 - Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

Group Code: CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

220.5 – Common Working File (CWF) Edits
(Rev.11388, Issued:04-29, 22; (Effective:02-10-22; Implementation:10-03-22)

The common working file (CWF) shall apply the following limitations to lung cancer screening with LDCT:

Allow one HCPCS code 71271 per annum. At least 11 full months must elapse from the date of the last screening. **NOTE:** This edit shall be overridable.

Reject HCPCS codes G0296 and 71271 claims lines for beneficiaries that are not between the ages of 50 and 77 (55 and 77 for DOS prior to February 10, 2022).

NOTE: Effective December 31, 2020, HCPCS code G0297 is end-dated and replaced with 71271.

230 – Screening for Hepatitis B Virus (HBV)
(Rev. 3831, Issued: 08-04-17, Effective: 09-28-16, Implementation: 10- 02- 17, October 2, 2017 - analysis and design; January 2, 2018 - testing and implementation)

Effective for services furnished on or after September 28, 2016, an initial screening for hepatitis B virus infection (HBV) is covered for asymptomatic, non-pregnant adolescents and adults at high risk for HBV infection. “High risk” is defined as persons born in countries and regions with high prevalence of HBV infection (i.e., ≥ 2%), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (i.e., ≥ 8%), HIV-positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection.

In addition, CMS has determined that repeated screening would be appropriate annually only for beneficiaries with continued high risk (men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) who do not receive hepatitis B vaccination.

A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative hepatitis B surface antigen (HBsAg) test results. See section 170 of this chapter for coverage and billing instructions for pregnant beneficiaries.

Effective for claims with dates of service on or after September 28, 2016, the claims processing instructions for payment of screening for hepatitis B virus will apply to the following HCPCS and CPT codes:

- HBV screening for asymptomatic, non-pregnant adolescents and adults at high risk - code G0499

- HBV screening for pregnant women – CPT codes 86704, 86706, 87340 and 87341

A. Frequency

HBV screening for asymptomatic, non-pregnant adolescents and adults at high risk (HCPCS code G0499)

- A single, one-time screening test is covered for asymptomatic, non pregnant adolescents and adults who do meet the high risk definition above.

- Repeat screening for high risk persons is covered annually only for persons who have continued high risk who do not receive hepatitis B vaccination .

Note: Annual means a full 11 months must elapse following the month in which the previous negative screening took place.

Note for ESRD: Effective for claims with dates of service on or after September 28, 2016 submitted with G0499 – "HepB screen high risk indiv, for asymptomatic non-pregnant beneficiaries" and ICD-10 diagnosis code N18.6, End Stage Renal Disease, all of the preceding requirements shall be bypassed and the claim shall be allowed to pay, no matter what other ICD-10 diagnosis codes may appear on the claim.

HBV screening for pregnant women (CPT codes 86704, 86706, 87340 and 87341)

- One occurrence per pregnancy of screening for HBV in pregnant women, and

- One additional occurrence per pregnancy of screening for HBV in pregnant women who are at continued risk

B. Determination of High Risk for Hepatitis B Disease

The determination of "high risk for HBV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit, and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

Note: See Pub. 100-03, Medicare National Coverage Determinations (NCD) Manual §210.6 for complete coverage guidelines.

230.1 – Institutional Billing Requirements

(Rev. 3831, Issued: 08-04-17, Effective: 09-28-16, Implementation: 10- 02- 17, October 2, 2017 - analysis and design; January 2, 2018 - testing and implementation)

Effective for claims with dates of service on or after September 28, 2016, providers may use the following types of bill (TOBs) when submitting claims for HBV screening, HCPCS G0499, 86704, 86706, 87340, and 87341: 13X, 14X, 72X, and 85X. Deductible and coinsurance do not apply. Service line-items on other TOBs shall be denied.

The service shall be paid on the basis shown below:

- Outpatient hospitals – TOB 13X - based on Outpatient Prospective Payment System
- Non-patient laboratory specimen – TOB 14X – based on laboratory fee schedule
- End Stage Renal Disease facilities (ESRDs) – TOB 72X – based on ESRD PPS when submitted with code G0499 and diagnosis code N18.6. HBV is not separately payable for (ESRD TOB 72X) unless reported with Modifier AY.
- Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost when the revenue code is not 096X, 097X, and 098X

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

NOTE: Beneficiary coinsurance and deductibles do not apply to claim lines containing HCPCS G0499, and CPT codes 86704, 86706, 87340, and 87341.

NOTE: Medicare Administrative Contractors shall contractor-price HBV screening claims, HCPCS G0499, with dates of service September 28, 2016 through December 31, 2017.

230.2 – Professional Billing Requirements

(Rev. 3831, Issued: 08-04-17, Effective: 09-28-16, Implementation: 10- 02- 17, October 2, 2017 - analysis and design; January 2, 2018 - testing and implementation)

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening, CPT codes 86704, 86706, 87340, 87341, and HCPCS G0499, only when services are ordered by the following provider specialties found on the provider's enrollment record:

01 - General Practice
08 - Family Practice
11 - Internal Medicine
16 - Obstetrics/Gynecology
37 - Pediatric Medicine
38 - Geriatric Medicine
42 – Certified Nurse Midwife
50 - Nurse Practitioner
89 - Certified Clinical Nurse Specialist
97 - Physician Assistant

Claims ordered by providers other than the specialty types noted above will be denied.

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening, 86704, 86706, 87340, 87341, and G0499, only when submitted with one of the following place of service (POS) codes:

11 – Physician's Office

19- Off Campus Outpatient Hospital
22 – On Campus Outpatient Hospital
49 – Independent Clinic
71 – State or Local Public Health Clinic
81-Independent Laboratory
Claims submitted without one of the POS codes noted above will be denied.

NOTE: Beneficiary coinsurance and deductibles do not apply to claim lines containing CPT codes 86704, 86706, 87340, 87341, and HCPCS G0499.

NOTE: Medicare Administrative Contractors shall contractor-price HBV screening claims, HCPCS G0499, with dates of service September 28, 2016 through December 31, 2017.

230.3 – Diagnosis Code Reporting Requirements

(Rev.11035, Issued:10-13-21, Effective: 11-17-21; Implementation: 11-17-21)

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening, HCPCS G0499, only when services are reported with both of the following diagnosis codes denoting high risk:

Z11.59 Encounter for screening for other viral disease,

and,

Z72.89 Other Problems related to life style

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening, HCPCS G0499, for subsequent visits only when services are reported with the following diagnosis codes:

Z11.59, **and,** one of the high risk diagnosis codes below:

- F11.10 Opioid abuse, uncomplicated
- F11.11 Opioid abuse, in remission
- F11.120 Opioid abuse with intoxication, uncomplicated
- F11.121 Opioid abuse with intoxication delirium
- F11.122 Opioid abuse with intoxication with perceptual disturbance
- F11.13 Opioid abuse with withdrawal
- F11.14 Opioid abuse with opioid-induced mood disorder
- F11.150 Opioid abuse with opioid-induced psychotic disorder with delusions
- F11.151 Opioid abuse with opioid-induced psychotic disorder with hallucinations
- F11.181 Opioid abuse with opioid-induced sexual dysfunction
- F11.182 Opioid abuse with opioid-induced sleep disorder
- F11.188 Opioid abuse with other opioid-induced disorder
- F11.20 Opioid dependence, uncomplicated

F11.21 Opioid dependence, in remission

F11.220 Opioid dependence with intoxication, uncomplicated

F11.221 Opioid dependence with intoxication delirium

F11.222 Opioid dependence with intoxication with perceptual disturbance
F11.23 Opioid dependence with withdrawal
F11.24 Opioid dependence with opioid-induced mood disorder
F11.250 Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251 Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259 Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.281 Opioid dependence with opioid-induced sexual dysfunction
F11.282 Opioid dependence with opioid-induced sleep disorder
F11.288 Opioid dependence with other opioid-induced disorder
F11.90 Opioid use, unspecified, uncomplicated
F11.920 Opioid use, unspecified with intoxication, uncomplicated
F11.921 Opioid use, unspecified with intoxication delirium
F11.922 Opioid use, unspecified with intoxication with perceptual disturbance
F11.929 Opioid use, unspecified with intoxication, unspecified
F11.93 Opioid use, unspecified with withdrawal
F11.94 Opioid use, unspecified with opioid-induced mood disorder
F11.950 Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11.951 Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11.959 Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11.981 Opioid use, unspecified with opioid-induced sexual dysfunction
F11.982 Opioid use, unspecified with opioid-induced sleep disorder
F11.988 Opioid use, unspecified with other opioid-induced disorder
F13.10 Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.11 Sedative, hypnotic or anxiolytic abuse, in remission
F13.120 Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13.121 Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.129 Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F13.130 Sedative, hypnotic or anxiolytic abuse with withdrawal, uncomplicated
F13.131 Sedative, hypnotic or anxiolytic abuse with withdrawal delirium
F13.132 Sedative, hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance
F13.14 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disord
F13.150 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic dis
F13.151 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic dis
F13.159 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic dis
F13.180 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disor
F13.181 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfu
F13.182 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disord
F13.188 Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disord
F13.20 Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21 Sedative, hypnotic or anxiolytic dependence, in remission

F13.220 Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221 Sedative, hypnotic or anxiolytic dependence with intoxication delirium

F13.229 Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13.230 Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231 Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13.232 Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.239 Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F13.24 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood
F13.250 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psycho
F13.251 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psycho hallucinations
F13.259 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psycho
F13.26 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persist
F13.27 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persist
F13.280 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiet
F13.281 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual
F13.282 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep d
F13.288 Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced d
F13.90 Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F13.920 Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated
F13.921 Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13.929 Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
F13.930 Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
F13.931 Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium
F13.932 Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances
F13.939 Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
F13.94 Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mo
F13.950 Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced ps delusions
F13.951 Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced ps hallucinations
F13.959 Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced ps
F13.96 Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced

F14.150 Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14.151 Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14.159 Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180 Cocaine abuse with cocaine-induced anxiety disorder
F14.181 Cocaine abuse with cocaine-induced sexual dysfunction
F14.182 Cocaine abuse with cocaine-induced sleep disorder
F14.188 Cocaine abuse with other cocaine-induced disorder
F14.20 Cocaine dependence, uncomplicated
F14.21 Cocaine dependence, in remission
F14.220 Cocaine dependence with intoxication, uncomplicated
F14.221 Cocaine dependence with intoxication delirium
F14.222 Cocaine dependence with intoxication with perceptual disturbance
F14.229 Cocaine dependence with intoxication, unspecified
F14.23 Cocaine dependence with withdrawal
F14.24 Cocaine dependence with cocaine-induced mood disorder
F14.250 Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251 Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.259 Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280 Cocaine dependence with cocaine-induced anxiety disorder
F14.281 Cocaine dependence with cocaine-induced sexual dysfunction
F14.282 Cocaine dependence with cocaine-induced sleep disorder
F14.288 Cocaine dependence with other cocaine-induced disorder
F14.90 Cocaine use, unspecified, uncomplicated
F14.920 Cocaine use, unspecified with intoxication, uncomplicated
F14.921 Cocaine use, unspecified with intoxication delirium
F14.922 Cocaine use, unspecified with intoxication with perceptual disturbance
F14.929 Cocaine use, unspecified with intoxication, unspecified
F14.93 Cocaine use, unspecified with withdrawal
F14.94 Cocaine use, unspecified with cocaine-induced mood disorder
F14.950 Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14.951 Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
F14.959 Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F14.980 Cocaine use, unspecified with cocaine-induced anxiety disorder
F14.981 Cocaine use, unspecified with cocaine-induced sexual dysfunction
F14.982 Cocaine use, unspecified with cocaine-induced sleep disorder
F14.988 Cocaine use, unspecified with other cocaine-induced disorder
F15.10 Other stimulant abuse, uncomplicated
F15.11 Other stimulant abuse, in remission
F15.120 Other stimulant abuse with intoxication, uncomplicated
F15.121 Other stimulant abuse with intoxication delirium
F15.122 Other stimulant abuse with intoxication with perceptual disturbance
F15.129 Other stimulant abuse with intoxication, unspecified
F15.13 Other stimulant abuse with withdrawal
F15.14 Other stimulant abuse with stimulant-induced mood disorder

F15.150 Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15.151 Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15.159 Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15.180 Other stimulant abuse with stimulant-induced anxiety disorder
F15.181 Other stimulant abuse with stimulant-induced sexual dysfunction
F15.182 Other stimulant abuse with stimulant-induced sleep disorder
F15.188 Other stimulant abuse with other stimulant-induced disorder
F15.20 Other stimulant dependence, uncomplicated
F15.21 Other stimulant dependence, in remission
F15.220 Other stimulant dependence with intoxication, uncomplicated
F15.221 Other stimulant dependence with intoxication delirium
F15.222 Other stimulant dependence with intoxication with perceptual disturbance
F15.229 Other stimulant dependence with intoxication, unspecified
F15.23 Other stimulant dependence with withdrawal
F15.24 Other stimulant dependence with stimulant-induced mood disorder
F15.250 Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.251 Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15.259 Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280 Other stimulant dependence with stimulant-induced anxiety disorder
F15.281 Other stimulant dependence with stimulant-induced sexual dysfunction
F15.282 Other stimulant dependence with stimulant-induced sleep disorder
F15.288 Other stimulant dependence with other stimulant-induced disorder
F15.90 Other stimulant use, unspecified, uncomplicated
F15.920 Other stimulant use, unspecified with intoxication, uncomplicated
F15.921 Other stimulant use, unspecified with intoxication delirium
F15.922 Other stimulant use, unspecified with intoxication with perceptual disturbance
F15.929 Other stimulant use, unspecified with intoxication, unspecified
F15.93 Other stimulant use, unspecified with withdrawal
F15.94 Other stimulant use, unspecified with stimulant-induced mood disorder
F15.950 Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15.951 Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15.959 Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
F15.980 Other stimulant use, unspecified with stimulant-induced anxiety disorder
F15.981 Other stimulant use, unspecified with stimulant-induced sexual dysfunction
F15.982 Other stimulant use, unspecified with stimulant-induced sleep disorder
F15.988 Other stimulant use, unspecified with other stimulant-induced disorder
Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transm
Z20.5 Contact with and (suspected) exposure to viral hepatitis
Z72.52 High risk homosexual behavior
Z72.53 High risk bisexual behavior

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT codes 86704, 86706, 87340 and 87341) in pregnant women only when services are reported with the following diagnosis codes:

Z11.59 - Encounter for screening for other viral diseases, and one of the following diagnosis codes below:

Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01 Encounter for supervision of normal first pregnancy, first trimester
Z34.02 Encounter for supervision of normal first pregnancy, second trimester
Z34.03 Encounter for supervision of normal first pregnancy, third trimester
Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81 Encounter for supervision of other normal pregnancy, first trimester
Z34.82 Encounter for supervision of other normal pregnancy, second trimester
Z34.83 Encounter for supervision of other normal pregnancy, third trimester
Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester
For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT codes 86704, 86706, 87340 and 87341) in pregnant women at high risk only when services are reported with the following diagnosis codes:

Z11.59 - Encounter for screening for other viral diseases**, and,**

Z72.89 - Other problems related to lifestyle, **and,** also one of the following diagnosis codes below:

O09.90 Supervision of high risk pregnancy, unspecified, unspecified

trimesterO09.91 Supervision of high risk pregnancy, unspecified, first

trimester O09.92 Supervision of high risk pregnancy, unspecified, second

trimester O09.93 Supervision of high risk pregnancy, unspecified, third

trimester

230.4 – Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

(Rev.11035, Issued:10-13-21, Effective: 11-17-21; Implementation: 11-17-21)

Contractors shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when rejecting payment for HBV screening:

- Rejecting services submitted on a TOB other than 13X, 14X, 72X, or 85X:

CARC 170 - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N95 – This provider type/provider specialty may not bill this service.

MSN 21.25: This service was denied because Medicare only covers this service in certain settings.
Spanish Version: “El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code CO (Contractual Obligation) assigning financial liability to the provider

a. Denying services where previous HBV screening, HCPCS G0499, is paid in history for claims with dates of service on and after September 28, 2016, or if the beneficiary’s claim history shows claim lines containing CPT codes 86704, 86706, 87340 and 87341 submitted in the previous 11 full months:

CARC 119: “Benefit maximum for this time period or occurrence has been reached.”

RARC N386: “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 with or without GA modifieror a claim –line is received with a GA modifier indicating a signed ABN is on file).

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim line-item is received with a GZ modifier indicating no signed ABN is on file and occurrence code 32 is not present).

(Part A only) MSN 15.19: “Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case tothe LCD, and send information from your doctor if you think it could change our decision. Call 1-800MEDICARE (1-800-633-4227) for a copy of the LCD”.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médicosi piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al1-800-MEDICARE (1800-633-4227).

MSN 15.20: "The following policies NCD 210.6 were used when we made this decision."
Spanish Version – "Las siguientes políticas NCD 210.6fueron utilizadas cuando se tomó esta decisión."

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

- Denying services for HBV screening, HCPCS G0499, when ICD-10 diagnosis code Z72.89 and Z11.59 are not present on the claim:

CARC 167 – "This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF),if present."

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

(Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case tothe LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médicosi piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión."

Group Code: CO (Contractual Obligation)

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

- Denying services for HBV screening, HCPCS G0499, for subsequent visits, when ICD-10 diagnosis code Z11.59, and one of the appropriate high-risk ICD-10 diagnosis codes noted in section 230.3 are not present on the claim:

CARC 167 – "This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF),if present."

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

(Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case tothe LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médicosi piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión."

Group Code: CO (Contractual Obligation)

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

- Denying claim lines for HBV screening, HCPCS G0499, without the appropriate POS code:

CARC 171 – Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N428 - Not covered when performed in certain settings.

Group Code: CO (Contractual Obligation)

MSN 21.25 - This service was denied because Medicare only covers this service in certain settings.

Spanish Version: “El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

- Denying claim lines for HBV screening, HCPCS G0499, that are not submitted from the appropriate provider specialties:

CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMSwebsite. If you do not have web access, you may contact the contractor to request a copyof the NCD.”

MSN 21.18 - This item or service is not covered when performed or ordered by this provider.
Spanish Version: “Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor.”

MSN 15.20: “The following policies NCD 210.6 were used when we made this decision.”
Spanish Version – “Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión.”

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim line-item is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying services where previous HBV screening, HCPCS 86704, 86706, 87340 or87341, is paid during the same pregnancy period or more than two screenings are paid to women that are at high risk:

CARC 119: “Benefit maximum for this time period or occurrence has been reached.”

RARC N362: “The number of days or units of service exceeds our acceptable maximum.”

RARC N386 – “This decision was based on a National Coverage Determination (NCD).An NCD provides a coverage determination as to whether a particular item or service is

covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copyof the NCD."

(Part A Only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case tothe LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médicosi piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al1-800-MEDICARE (1-800-633-4227).

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file and occurrence code 32 is not present)

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with occurrence code 32 with or without a GZ modifier indicating no signed ABN is on file).

b. Denying services for HBV screening, HCPCS G0499, when ICD-10 diagnosis code Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93 is present on the claim:

CARC 167 – "This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF),if present."

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Group Code: CO (Contractual Obligation)

(Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case tothe LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico

si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al1-800-MEDICARE (1-800-633-4227).

MSN 15.20: “The following policies NCD 210.6 were used when we made this decision.” Spanish Version – “Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión.”

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

- Denying claim lines for HBV screening, HCPCS G0499 for a subsequent HBV screening test for non-pregnant, high risk beneficiary when a claim line for an initial HBV screening has not yet been posted in history:

CARC B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Group Code: CO (Contractual Obligation).

MSN 21.21: This service was denied because Medicare only covers this service under certain circumstances.
Spanish Version - Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.

(Part A only) MSN 15.19: “Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case tothe LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD”.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médicosi piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al1-800-MEDICARE (1-800-633-4227).

MSN 15.20: “The following policies NCD 210.6 were used when we made this decision.”
Spanish Version – “Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión.”

NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 sothat, when used for the same line item, both messages will appear on the same MSN

240 - Prolonged Preventive Services Codes

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services (PPS) may be reported as an add-on to a covered preventive service that is payable from the Medicare Physician Fee Schedule. PPS codes are treated as a preventive service and both coinsurance and deductible do not apply when billed with a covered preventive service which is part of a particular subset of procedure codes listed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html

250. Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Infection Prevention

(Rev. 12987; Issued: 12- 05-24 Effective: 09-30-24; Implementation:04-07-25)

250.1 Policy

(Rev. 12987; Issued: 12- 05-24 Effective: 09-30-24; Implementation:04-07-25)

The Centers for Medicare & Medicaid Services (CMS) has determined that Pre-Exposure Prophylaxis (PrEP) using antiretroviral drugs to prevent Human Immunodeficiency Virus (HIV) is covered as an additional preventive service under §1861(ddd)(1) of the Social Security Act (the Act).

Effective September 30, 2024, CMS covers PrEP using antiretroviral drugs approved by the U.S. Food and Drug Administration (FDA) to prevent HIV in individuals at increased risk of HIV acquisition. The determination of whether an individual is at increased risk for HIV is made by the physician or health care practitioner who assesses the individual's history. CMS also covers furnishing HIV PrEP using antiretroviral drugs, including the supplying or dispensing of these drugs and the administration of injectable PrEP.

For individuals being assessed for or using PrEP to prevent HIV, CMS covers all the following as an additional preventive service:

a) Up to eight individual counseling visits, every 12 months, that include HIV risk assessment (initial or continued assessment of risk), HIV risk reduction, and medication adherence. Counseling must be furnished by a physician or other health care practitioner. Individuals must be competent and alert at the time that counseling is provided.

b) Up to eight HIV screening tests every 12 months.

c) A single screening for hepatitis B virus (HBV).

These screening tests are covered when the appropriate FDA-approved laboratory tests and point of care tests are used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations.

Further information, including coverage guidelines can be found in Publication 100-03, Section 210.15.

250.2 Healthcare Common Procedural Coding System (HCPCS) Drug Codes and Diagnosis Codes

(Rev. 12987; Issued: 12- 05-24 Effective: 09-30-24; Implementation:04-07-25)

CMS has approved the following HCPCS and diagnosis codes for PrEP for HIV infection prevention.

A. Drug HCPCS Codes

J0799 - FDA approved prescription drug, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv), not otherwise classified, Short Descriptor: Hiv prep, fda approved, noc

J0750 - Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv), Short Descriptor: Hiv prep, ftc/tdf 200/300mg

J0751 - Emtricitabine 200mg and tenofovir alafenamide 25mg, oral, fda approved prescription, only for use as pre-exposure prophylaxis (not for use as treatment of hiv), Short Descriptor: Hiv prep, ftc/tad 200/25mg

J0739 - Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv) Short Descriptor: Injection, cabotegravir, 1 mg

G0012 - Injection of pre-exposure prophylaxis (prep) drug for hiv prevention, under skin or into muscle, Short Descriptor: Inj, prep drug for hiv prev

B. Counseling HCPCS Codes

G0011 - Individual counseling for pre-exposure prophylaxis (PrEP) by physician or QHP to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence, 15-30 minutes

G0013 - Individual counseling for pre-exposure prophylaxis (PrEP) by clinical staff to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence

C. Pharmacy Supplying Fees HCPCS Codes

a. Prior to 01/01/2025

Q0516 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 30-days, Short Descriptor: Supply fee hiv prep oral 30-days

Q0517 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 60-days, Short Descriptor: Supply fee hiv prep oral 60-days

Q0518 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 90-days, Short Descriptor: Supply fee hiv prep oral 90-days

Q0519 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 30-days, Short Descriptor: Supply fee hiv prep inj 30

Q0520 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 60-days, Short Descriptor: Supply fee hiv prep inj 60

b. On or after 1/1/2025

Q0521 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription, Short descriptor: Supply fee hiv prep fda appr

D. Diagnosis Codes:

A51.31 Condyloma latum

A51.32 Syphilitic alopecia

A51.39 Other secondary syphilis of skin

A51.41 Secondary syphilitic meningitis

A51.42 Secondary syphilitic female pelvic disease

A51.43 Secondary syphilitic oculopathy

A51.44 Secondary syphilitic nephritis

A51.45 Secondary syphilitic hepatitis

A51.46 Secondary syphilitic osteopathy

A51.49 Other secondary syphilitic conditions

A52.01 Syphilitic aneurysm of aorta

A52.02 Syphilitic aortitis

A52.03 Syphilitic endocarditis

A52.04 Syphilitic cerebral arteritis

A52.05 Other cerebrovascular syphilis

A52.06 Other syphilitic heart involvement

A52.09 Other cardiovascular syphilis

A52.11 Tabes dorsalis

A52.12 Other cerebrospinal syphilis

A52.13 Late syphilitic meningitis

A52.14 Late syphilitic encephalitis

A52.15 Late syphilitic neuropathy

A52.16 Charcot's arthropathy (tabetic)

A52.17 General paresis

A52.19 Other symptomatic neurosyphilis

A52.2 Asymptomatic neurosyphilis

A52.71 Late syphilitic oculopathy

A52.72 Syphilis of lung and bronchus

A52.73 Symptomatic late syphilis of other respiratory organs

A52.74 Syphilis of liver and other viscera

A52.75 Syphilis of kidney and ureter

A52.76 Other genitourinary symptomatic late syphilis

A52.77 Syphilis of bone and joint

A52.78 Syphilis of other musculoskeletal tissue

A52.79 Other symptomatic late syphilis

A53.0 Latent syphilis, unspecified as early or late

A54.00 Gonococcal infection of lower genitourinary tract, unspecified

A54.01 Gonococcal cystitis and urethritis, unspecified

A54.02 Gonococcal vulvovaginitis, unspecified

A54.03 Gonococcal cervicitis, unspecified

A54.09 Other gonococcal infection of lower genitourinary tract

A54.1 Gonococcal infection of lower genitourinary tract with periurethral and accessory gland abscess

A54.21 Gonococcal infection of kidney and ureter

A54.22 Gonococcal prostatitis

A54.23 Gonococcal infection of other male genital organs

A54.24 Gonococcal female pelvic inflammatory disease

A54.29 Other gonococcal genitourinary infections

A54.31 Gonococcal conjunctivitis

A54.32 Gonococcal iridocyclitis

A54.33 Gonococcal keratitis

A54.39 Other gonococcal eye infection

A54.41 Gonococcal spondylopathy

A54.42 Gonococcal arthritis

A54.43 Gonococcal osteomyelitis

A54.49 Gonococcal infection of other musculoskeletal tissue

A54.5 Gonococcal pharyngitis

A54.6 Gonococcal infection of anus and rectum

A54.81 Gonococcal meningitis

A54.82 Gonococcal brain abscess

A54.83 Gonococcal heart infection

A54.84 Gonococcal pneumonia

A54.85 Gonococcal peritonitis

A54.86 Gonococcal sepsis

A54.89 Other gonococcal infections

A56.01 Chlamydial cystitis and urethritis

A56.02 Chlamydial vulvovaginitis

A56.09 Other chlamydial infection of lower genitourinary tract

A63.8 Other specified predominantly sexually transmitted diseases

A64 Unspecified sexually transmitted disease

F11.10 Opioid abuse, uncomplicated

F11.20 Opioid dependence, uncomplicated

F11.21 Opioid dependence, in remission

F11.90 Opioid use, unspecified, uncomplicated

Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission

Z11.4 Encounter for screening for human immunodeficiency virus [HIV]

Z11.59 Encounter for screening for other viral diseases

Z13.29 Encounter for screening for other suspected endocrine disorder

Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission

Z20.5 Contact with and (suspected) exposure to viral hepatitis

Z20.6 Contact with and (suspected) exposure to human immunodeficiency virus [HIV]

Z20.828 Contact with and (suspected) exposure to other viral communicable diseases

Z20.89 Contact with and (suspected) exposure to other communicable diseases

Z20.9 Contact with and (suspected) exposure to unspecified communicable disease

Z29.81 Encounter for HIV pre-exposure prophylaxis

Z32.00 Encounter for pregnancy test, result unknown

Z32.01 Encounter for pregnancy test, result positive

Z32.02 Encounter for pregnancy test, result negative

Z72.51 High risk heterosexual behavior

Z72.52 High risk homosexual behavior

Z72.53 High risk bisexual behavior

Z72.89 Other problems related to lifestyle

Z79.899 Other long term (current) drug therapy

Z86.59 Personal history of other mental and behavioral disorders

Z87.898 Personal history of other specified conditions

250.3- Billing and Payment Requirements

(Rev. 12987; Issued: 12- 05-24 Effective: 09-30-24; Implementation:04-07-25)

Effective for claims with dates of service on or after September 30, 2024:

A. Contractors shall accept and pay for PrEP for HIV claims using antiretroviral drugs (HCPCS J0739, J0799, J0750, or J0751) approved by the US Food and Drug Administration (FDA) to prevent HIV infection in individuals at increased risk of HIV acquisition using one of the diagnosis codes listed in 250.2(D).

Contractors shall accept and pay for up to (8) counseling sessions related to PrEP for HIV medications every 12 months using HCPCS G0011or G0013.

Contractors shall not apply the deductible or co-insurance for PrEP claims for HIV prevention medications or related services, including counseling, HIV and HBV screening.

B. Contractors shall pay for code G0011 on 085X TOB claims submitted with revenue code 96x, 97x, or 98x.

NOTE: Payment is based on 115% of the Medicare Physician Fee Schedule.

C. Contractors shall pay code G0011 on Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) claims. RHCs shall bill G0011 with a -CG Modifier and payment is at the all-inclusive rate (AIR). FQHCs shall bill G0011 along with the appropriate FQHC specific payment code (G0466 or G0467). Payment is at the lessor of charges or the FQHC PPS rate. PrEP for HIV Counseling HCPCS Code G0011 is considered a visit for RHCs and FQHCs when furnished by an RHC or FQHC Practitioner.

D. Contractors shall accept and pay up to eight HIV screening tests (codes G0432 - Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening; G0433 - Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening; G0435 - Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening; G0475 - Hiv antigen/antibody, combination assay, screening; or 80081 – Organ Disease Oriented Panel) every 12 months when providing individual counseling for PrEP for HIV.

E. Contractors shall accept and pay a single Hep B Virus (HBV) screening test (codes G0499, 87340, 87341, 86704, 86706) for individuals being assessed for or using PrEP to prevent HIV. This is a once per life-time allowance.

NOTE: A single (one-time) screening for HBV is available under this NCD. NCD 210.6 Screening for Hepatitis B Virus (HBV) Infection is a separate benefit and continues to apply to eligible beneficiaries

F. Contractors shall only allow payment for supplying fees if billed on the same claim as the payable covered drug. RHCs and FQHCs do not need to enroll as a Medicare Part B pharmacy supplier or a DMEPOS pharmacy supplier to bill for PrEP for HIV drugs.

G. Deductible and coinsurance do not apply.

250.4 Messaging

(Rev. 12987; Issued: 12- 05-24 Effective: 09-30-24; Implementation:04-07-25)

Contractors shall deny the CWF rejected claims for G0011 or G0013 for more than eight separate LIDOS visit encounter claims within a 12-month period (for both professional and institutional claims combined) and use the following messages:

CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N640 - Exceeds number/frequency approved/allowed within time period.

Claim Adjustment Group Code - CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the line item).

MSN message: 41.14: This service/item was billed incorrectly. 41.14- Este servicio o artículo fue facturado incorrectamente.

Contractors shall deny the CWF rejected claim for G0432 ‘G0433’ G0435’ G0475’ or ‘80081’ for more than eight claims with different LIDOS within a 12-month period and use the following messages:

CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N640 - Exceeds number/frequency approved/allowed within time period.

Claim Adjustment Group Code - CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the line item).

MSN message: 41.14: This service/item was billed incorrectly. 41.14- Este servicio o artículo fue facturado incorrectamente.

Contractors shall deny the CWF rejected claim if an HBV screening is received with primary diagnosis code of Z29.81 and no PrEP HIV service have been submitted. and use the following messages:

CARC 96 – Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark

Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC – N386 This decision was based on a National Coverage Determination (NCD).

Claim Adjustment Group Code - CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the line item).

MSN message: 15.20 The following policies were used when we made this decision: NCD 210.15

Contractors shall deny the CWF rejected claim when the primary diagnosis code of Z29.81 is present on the Part B or Outpatient claim and claim has service for HIV or HBV that should apply to PrEP HIV services and use the following messages:

CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC – N386 This decision was based on a National Coverage Determination (NCD).

Claim Adjustment Group Code - CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the line item).

MSN message: 15.20 The following policies were used when we made this decision: NCD 210.15

Contractors shall deny claims that contain a pharmacy supplying fees HCPCS code listed in Section 250.2 and a covered drug for PrEP for HIV HCPCS code listed in Section 250.2 is not present on the same claim using the following messages:

> CARC 107: The related or qualifying claim/service was not identified on this claim.
>
> MSN 17.11: This item or service cannot be paid as billed.
>
> Group Code - CO (Contractual Obligation)

Contractors shall deny the claim if there is an acquisition HCPCS listed in Section 250.2 without a diagnosis code listed in Section 250.2 and use the following messages:

RARC N386 – This decision was based on a National Coverage Determination (NCD).

CARC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Claim Adjustment Group Code - CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the line item).

MSN message: 15.20 The following policies were used when we made this decision: NCD 210.15. Spanish version 15.20 - Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD-210.15.

Contractors shall deny claims that contain a visit HCPCS (G0011 or G0013) listed without one of the diagnosis codes in Section 250.2 for PreP for HIV claims and use the following messages:

RARC N386 – This decision was based on a National Coverage Determination (NCD).

CARC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Claim Adjustment Group Code - CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the line item).

MSN message: 15.20 The following policies were used when we made this decision: NCD 210.15

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Implementation Date	CR#
R13677CP	03/12/2026	Internet-Only Manual Update, Pub. 100-04, Chapter 18 (Preventive and Screening Services), Section 10.2.1	04/13/2026	14396
R13549CP	12/18/2025	Update to the Internet Only Manual (IOM) Publication 100-04, Chapter 18, Sections 150.1, 150.2.1, 150.3 and Chapter 32, Sections 12.1, 12.3, 320.3.3, 400.2.2, 400.2.3 and 400.2.3.1 for Coding Revisions to National Coverage Determination (NCDs) - October 2025 Change Request (CR) 14041	01/20/2026	14267
R13547CP	12/18/2025	Revisions to Publication 100-04, Medicare Claims Processing Manual, Chapters 9, 18, and Publication 100-02, Medicare Benefit Policy Manual, Chapter 13 To Include Updated Information	01/20/2026	14254
R13209CP	05/02/2025	National Coverage Determination (NCD) 210.15 - Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention	04/07/2025	13843
R13091CP	02/21/2025	Roster Billing for Hepatitis B - July 2025 Release	07/07/2025	13937
R13025CP	12/23/2024	Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 18 Section 60.3 and Chapter 32 Sections 11.3.5, 60.4.1, 60.5.2, 320.2 and 412.1 for Coding Revisions to the National Coverage Determinations (NCDs) - April 2025 (2 of 2) Change Request (CR) 13828	03/20/2025	13914
R12987CP	12/05/2024	National Coverage Determination (NCD) 210.15 - Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention- Rescinded and replaced by	04/07/2025	13843

Rev #	Issue Date	Subject	Implementation Date	CR#
		Transmittal 13209		
R12763CP	08/01/2024	Internet-Only Manual Update for Billing Code G0444 for Annual Depression Screening	01/06/2025	13710
R12435CP	12/28/2023	Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 18, Sections 20.2, 60.3 and Chapter 32, Sections 50.4.1, 200.2 for Coding Revisions to the National Coverage Determinations (NCDs)--April 2024 Change Request (CR) 13391	01/29/2024	13461
R12299CP	10/12/2023	An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final Rule, Including (1) Removal of Selected NCDs (NCD 160.22 Ambulatory EEG Monitoring), and, (2) Expanding Coverage of Colorectal Cancer Screening - Full Agile Pilot CR	11/13/2023	13017
R12070CP	06/07/2023	Internet Only Manual Update to Publication 100-04, Chapters 9 and 18 to Clarify Vaccine Payment Instructions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)	07/10/2023	13218
R11902CP	03/16/2023	Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 18 Sections 50.3-50.4, and Chapter 32 Sections 130.1, 170.2 for Coding Revisions to National Coverage Determinations (NCDs)--July 2023 Change Request (CR) 13070	04/17/2023	10104
R11865CP	02/16/2023	An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final	02/27/2023	13017

Rev #	Issue Date	Subject	Implementation Date	CR#
		Rule, Including (1) Removal of Selected NCDs (NCD 160.22 Ambulatory EEG Monitoring), and, (2) Expanding Coverage of Colorectal Cancer Screening - Full Agile Pilot CR Rescinded and replaced by Transmittal 12299		
R11843CP	02/09/2023	Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 18, Section 10.2.2.1, to Clarify the Payment Method on Vaccines for Critical Access Hospitals (CAHs)	03/09/2023	13074
R11824CP	01/27/2023	An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final Rule, Including (1) Removal of Selected NCDs (NCD 160.22 Ambulatory EEG Monitoring), and, (2) Expanding Coverage of Colorectal Cancer Screening - Full Agile Pilot CR-Rescinded and replaced by Transmittal 11865	02/27/2023	13017
R11759CP	12/21/2022	Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 18 Section 170.1 and Chapter 32 Section 270.2 due to the National Coverage Determinations (NCDs) April 2023 Change Request (CR) 12960	01/23/2023	12993
R11445CP	06/03/2022	Revisions to Chapters 3, “Inpatient Hospital Billing” of the Medicare Claims Processing Manual (Pub 100-04), 18, “Preventive and Screening Services” of the Medicare Claims Processing Manual (Pub 100-04), and 32 “Billing Requirements for Special Services” of the Medicare Claims Processing Manual (Pub 100-04) to	05/09/2022	12602

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		Update Coding		
R11392CP	05/02/2022	Revisions to Chapters 3, “Inpatient Hospital Billing” of the Medicare Claims Processing Manual (Pub 100-04), 18, “Preventive and Screening Services” of the Medicare Claims Processing Manual (Pub 100-04), and 32 “Billing Requirements for Special Services” of the Medicare Claims Processing Manual (Pub 100-04) to Update Coding - Rescinded and replaced by Transmittal 11445	05/09/2022	12602
R11388CP	04/29/2022	National Coverage Determination (NCD) 210.14 Reconsideration – Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)	10/03/2022	12691
R11362CP	04/22/2022	Claims Processing Instructions for the New Hepatitis B Vaccine Code 90759	07/05/2022	12686
R11355CP	04/14/2022	Update to Publication 100-04, Chapter 18 and Publication 100-02, Chapter 15, Section to Add Data Regarding Novel Coronavirus (COVID-19) and its Administration to Current Claims Processing Requirements and Other General Updates	05/16/2022	12634
R11348CP	04/07/2022	Revisions to Chapters 3, “Inpatient Hospital Billing” of the Medicare Claims Processing Manual (Pub 100-04), 18, “Preventive and Screening Services” of the Medicare Claims Processing Manual (Pub 100-04), and 32 “Billing Requirements for Special Services” of the Medicare Claims Processing Manual (Pub 100-04) to Update Coding- Rescinded and	05/09/2022	12602

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		replaced by Transmittal 11392		
R11322CP	03/29/2022	Claims Processing Instructions for the New Hepatitis B Vaccine Code 90759-Rescinded and replaced by Transmittal 11362	07/05/2022	12686
R11092CP	10/29/2021	Claims Processing Instructions for the New Pneumococcal 20-valent Conjugate Vaccine Code 90677	04/04/2022	12439
R11035CP	10/13/2021	Revisions to Chapters 3, 18, and 32 to Update Coding	11/17/2021	12377
R11021CP	10/01/2021	Revisions to Chapters 13, 18 And 32 To Update Coding	10/29/2021	12376
R10818CP	05/20/2021	National Coverage Determination (NCD) 210.3 - Screening for Colorectal Cancer (CRC)-Blood-Based Biomarker Tests	10/04/2021	12280
R10456CP	11/13/2020	**Update to Vaccine Services Editing**	04/05/2021	11975
R4508CP	01/31/2020	Quarterly Influenza Virus Vaccine Code Update - July 2020	07/06/2020	11603
R4364CP	08/16/2019	Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of Publication (Pub.) 100-04	11/18/2019	11403
R4225CP	02/01/2019	Update to Mammography Editing	07/01/2019	11132
R4150CP	10/26/2018	Update to Bone Mass Measurements (BMM) Code 77085 Deductible and Coinsurance	04/01/2019	10956

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R4141CP	09/27/2018	Quarterly Influenza Virus Vaccine Code Update - January 2019	01/07/2019	10871
R4127CP	09/05/2018	Quarterly Influenza Virus Vaccine Code Update - January 2019—Rescinded and replaced by Transmittal 4141	01/07/2019	10871
R4100CP	08/03/2018	Quarterly Influenza Virus Vaccine Code Update - January 2019 —Rescinded and replaced by Transmittal 4127	01/07/2019	10871
R4071CP	06/08/2018	Update of Internet Only Manual (IOM), Medicare Claims Processing Manual, Publication 100-04, Chapter 18-Preventive and Screening Services, and Chapter 35 - Independent Diagnostic Testing Facility (IDTF)	07/09/2018	10735
R3961CP	02/02/2018	Editing Update for Mammography Services	07/02/2018	10435
R3901CP	11/03/2017	Update to Pub 100-04, Chapter 18 Preventive and Screening Services - Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)	12/04/2017	10338
R3844CP	08/18/2017	Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services	01/02/2018	10181
R3827CP	08/04/2017	Quarterly Influenza Virus Vaccine Code Update - January 2018	01/02/2018	10196
R3835CP	08/16/2017	Screening for the Human Immunodeficiency Virus (HIV)	10/02/2017	9980

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		Infection		
R3831CP	08/04/2017	Screening for Hepatitis B Virus (HBV) Infection	10/02/2017	9859
R3848CP	08/25/2017	Updates to Pub. 100-04, Chapter 18 Preventive and Screening Services and Chapter 32 Billing Requirements for Special Services and Publication 100-03, Chapter 1 Coverage Determinations Part 4	09/26/2017	10199
R3804CP	06/29/2017	Screening for Hepatitis B Virus (HBV) Infection	10/02/2017	9859
R3793CP	06/09/2017	Screening for Hepatitis B Virus (HBV) Infection—Rescinded and replaced by Transmittal 3804	10/02/2017	9859
R3778CP	05/24/2017	Screening for the Human Immunodeficiency Virus (HIV) Infection	10/02/2017	9980
R3766CP	05/05/2017	Screening for the Human Immunodeficiency Virus (HIV) Infection--Reissue	10/02/2017	9980
R3766CP	05/05/2017	Screening for the Human Immunodeficiency Virus (HIV) Infection	10/02/2017	9980
R3763CP	04/28/2017	Payment for Moderate Sedation Services Furnished with Colorectal Cancer Screening Tests	10/02/2017	10075

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R3761CP	04/28/2017	Screening for Hepatitis B Virus (HBV) Infection—Rescinded and replaced by Transmittal 3793	10/02/2017	9859
R3711CP	02/03/2017	Implementation of New Influenza Virus Vaccine Code	07/03/2017	9876
R3669CP	12/02/2016	HCPCS Code Update for Preventive Services	01/03/2016	9888
R3621CP	10/07/2016	Billing of Vaccine Services on Hospice Claims	10/03/2016	9052
R3617CP	09/30/2016	Implementation of New Influenza Virus Vaccine Code	01/03/2016	9793
R3615CP	09/23/2016	Update to Hepatitis B Deductible and Coinsurance and Screening Pap Smears Claims Processing Information	12/27/2016	9778
R3540CP	06/10/2016	Billing of Vaccine Services on Hospice Claims – Rescinded and replaced by Transmittal 3621	10/03/2016	9052
R3536CP	06/08/2016	CMS Mammography Quality Standards Act (MQSA) File Reformatting-Implementation	10/03/2016	9492
R3522CP	05/13/2016	Update to Internet-Only-Manual Publication 100-04, Chapter 18, Section 30.6	06/14/2016	9606
R3503CP	04/28/2016	Billing of Vaccine Services on Hospice Claims – Rescinded and replaced by Transmittal 3540	10/03/2016	9052
R3463CP	02/12/2016	CMS Mammography Quality Standards Act (MQSA) File Reformatting-Implementation – Rescinded and replaced by Transmittal 3536	10/03/2016	9492

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R3461CP	02/05/2016	Screening for the Human Immunodeficiency Virus (HIV) Infection	03/07/2016	9403
R3460CP	02/05/2016	Screening for Cervical Cancer With Human Papillomavirus (HPV) Testing—National Coverage Determination (NCD)	03/07/2016	9434
R3436CP	12/30/2015	National Coverage Determination (NCD) for Screening for Colorectal Cancer Using Cologuard™ - A Multitarget Stool DNA Test	09/08/2015	9115
R3429CP	12/22/2015	New Influenza Virus Vaccine Code – Rescinded and replaced by Transmittal 3429	12/11/2015	9357
R3428CP	12/22/2015	Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)	01/04/2016	9271
R3403CP	11/09/2015	New Influenza Virus Vaccine Code – Rescinded and replaced by Transmittal 3429	12/11/2015	9357
R3393CP	11/05/2015	Reporting of Type of Bill (TOB) 014x for Billing Screening of Hepatitis C Virus (HCV) in Adults	04/04/2016	9360
R3374CP	10/15/2015	Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)	01/04/2015	9246
R3368CP	10/09/2015	New Values for Incomplete Colonoscopies Billed with Modifier 53	01/01/2016	9317
R3338CP	08/21/2015	Medicare Coverage of Screening for Lung Cancer with Low Dose Computed	01/04/2015	9246

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		Tomography (LDCT) – Rescinded and replaced by Transmittal 3374 (Sensitive/Controversial)		
R3329CP	08/14/2015	Update to Pub. 100-04, Chapter 18 to Provide Language-Only Changes for Updating ICD-10, the 02/12 version of the Form CMS-1500, and ASC X12	09/14/2015	8628
R3319CP	08/06/2015	National Coverage Determination (NCD) for Screening for Colorectal Cancer Using Cologuard™ - A Multitarget Stool DNA Test – Rescinded and replaced by Transmittal 3436	09/08/2015	9115
R3318CP	08/07/2015	Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV) – Rescinded and replaced by Transmittal 3428	01/04/2016	9271
R3315CP	08/06/2015	New and Revised Place of Service Codes (POS) for Outpatient Hospital	01/04/2016	9231
R3301CP	08/06/2015	Claims Processing Instructions for Diagnostic Digital Breast Tomosynthesis	01/04/2016	9191
R3285CP	06/19/2015	Screening for Hepatitis C Virus (HCV) in Adults – Implementation of Additional Common Working File (CWF) and Shared System Maintainer (SSMs) Edits	10/05/2015	9200
R3232CP	04/03/2015	Preventive and Screening Services — Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy	01/05/2015	8874

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R3215CP	03/11/2015	Screening for Hepatitis C Virus (HCV) in Adults	01/05/2015	8871
R3160CP	01/07/2015	Preventive and Screening Services — Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy – Rescinded and replaced by Transmittal 3232	01/05/2015	8874
R3159CP	12/31/2015	Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations	02/02/2015	9051
R3146CP	12/11/2014	Preventive and Screening Services — Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy – Rescinded and replaced by Transmittal 3160	01/05/2015	8874
R3127CP	11/19/2014	Screening for Hepatitis C Virus (HCV) in Adults – Rescinded and replaced by Transmittal 3215	01/05/2015	8871
R3096CP	10/17/2014	Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) and Screening Fecal-Occult Blood Tests (FOBT)	11/18/2014	8881
R3094CP	10/10/2014	Preventive and Screening Services — Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy – Rescinded and replaced by Transmittal 3146	01/05/2015	8874

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R3063CP	09/05/2014	Screening for Hepatitis C Virus (HCV) in Adults – Rescinded and replaced by Transmittal 3127	01/05/2015	8871
R3042CP	08/22/2014	Preventive and Screening Services — Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy – Rescinded and replaced with Transmittal 3094 (Sensitive/Controversial)	01/05/2015	8874
R2824CP	11/22/2013	New Influenza Virus Vaccine Code	04/07/2014	8473
R2693CP	05/02/2013	New Influenza Virus and Hepatitis B Virus Vaccine Codes	10/07/2013	8249
R2575CP	10/26/2012	Editing Updating for Annual Wellness Visit (AWV)	04/01/2013	8107
R2476CP	05/23/2012	Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs (ICD-10)	02/27/2012	7610
R2446CP	04/26/2012	New Influenza Virus Vaccine Code	10/01/2012	7794
R2438CP	04/04/2012	Revised Editing for Hepatitis B Administration Code G0010	07/02/2012	7692
R2433CP	03/26/2012	Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	12/27/2011	7633
R2432CP	03/23/2012	Intensive Behavioral Therapy for Cardiovascular Disease	12/27/2011	7636
R2431CP	03/23/2012	Screening for Depression in Adults	12/27/2011	7637

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R2421CP	03/07/2012	Intensive Behavioral Therapy for Obesity	03/06/2012	7641
R2409CP	02/03/2012	Intensive Behavioral Therapy for Obesity – Rescinded and replaced by Transmittal 2421	03/06/2012	7641
R2402CP	01/26/2012	Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs (ICD-10) – Rescinded and replaced by Transmittal 2476	07/02/2012	7610
R2390CP	01/25/2012	Revised Editing for Hepatitis B Administration Code G0010 – Rescinded and replaced by Transmittal 2438	07/02/2012	7692
R2359CP	11/23/2011	Screening for Depression in Adults – Rescinded and replaced by Transmittal 2431	12/27/2011	7637
R2358CP	11/23/2011	Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse – Rescinded and replaced by Transmittal 2433	12/27/2011	7633
R2357CP	11/23/2011	Intensive Behavioral Therapy for Cardiovascular Disease – Rescinded and replaced by Transmittal 2432	12/27/2011	7636
R2337CP	10/28/2011	New Influenza Virus Vaccine Code	04/02/2012	7580
R2267CP	08/01/2011	Common Working File (CWF) Editing for Influenza Virus Vaccine and Pneumococcal Vaccine Codes	01/03/2012	7461
R2253CP	07/08/2011	Influenza Virus Vaccine	08/08/2011	7453

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R2233CP	05/27/2011	Medicare Preventive and Screening Services	06/28/2011	7423
R2199CP	04/22/2011	Screening for the Human Immunodeficiency Virus (HIV) Infection	07/06/2010	6786
R2163CP	02/23/2011	Screening for the Human Immunodeficiency Virus (HIV) Infection – Rescinded and replaced by Transmittal 2199	07/06/2010	6786
R2159CP	02/15/2011	Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)	04/04/2011	7079
R2154CP	02/11/2011	Payment Update and Common Working File (CWF) Editing for Influenza Virus Vaccine and Pneumococcal Vaccine Codes	07/05/2011	7128
R2109CP	12/03/2010	Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS) – Rescinded and replaced by Transmittal 2159	04/04/2011	7079
R2058CP	09/30/2010	Counseling to Prevent Tobacco Use	01/03/2011	7133
R1953CP	04/28/2010	Use of 12X Type of Bill (TOB) for Billing Colorectal Screening Services	10/04/2010	6760
R1935CP	03/23/2010	Screening for the Human Immunodeficiency Virus (HIV) Infection – Rescinded and replaced by Transmittal 2163	07/06/2010	6786
R1931CP	03/12/2010	Revision of the Internet Only Manual (IOM) to Remove References to “Purchased Diagnostic Test” and	06/14/2010	6627

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		Replace With Language Consistent With the Anti-Markup Rule		
R1918CP	02/19/2010	Screening for the Human Immunodeficiency Virus (HIV) Infection - Rescinded and replaced by Transmittal 1935	07/06/2010	6786
R1846CP	11/06/2009	Implementation of Common Working File (CWF) Editing for Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)	04/05/2009	6553
R1719CP	04/24/2009	Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) Updates	10/05/2009	6445
R1624CP	10/31/2008	Reporting of National Provider Identifiers (NPI) on Claims for Out-of-Jurisdiction Purchased Mammography Preventive Screening and Diagnostic Services	12/01/2008	6237
R1617CP	10/24/2008	Common Working File (CWF) Editing for Influenza Virus Vaccine and Pneumococcal Vaccine Codes	04/06/2009	6224
R1615CP	10/17/2008	Update to the Initial Preventive Physical Examination (IPPE) Benefit	01/05/2009	6223
R1586CP	09/05/2008	Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines	10/06/2008	6079
R1541CP	06/20/2008	Screening Pelvic Examinations	09/23/2008	6085
R1519CP	05/30/2008	Instructions for Institutional Providers and Suppliers Billing Self-Referred Mammography Claims Regarding the Attending/Referring Physician National Provider Identifier	06/30/2008	6023

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R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
R1459CP	02/22/2008	Comprehensive Outpatient Rehabilitation Facility (CORF) Billing Requirement Updates for Fiscal Year (FY) 2008	07/07/2008	5898
R1461CP	02/22/2009	Clarification to CR 5744 - Payment Allowance Update for the Influenza Virus Vaccine CPT 90660 and Further Instruction Regarding the Pneumococcal Vaccine CPT 90669	03/24/2008	5910
R1421CP	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R1387CP	12/07/2007	Mammography: Change Certification-Based Action From Return to Provider (RTP)/Return as Unprocessable to Reject/Denial	04/07/2008	5577
R1325CP	08/29/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes	01/07/2008	5680
R1308CP	07/20/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes – Replaced by Transmittal 1325 Sensitive/Controversial	01/07/2008	5680
R1278CP	06/29/2007	Update to Pub.100-04, Chapter 18, Section 10 for Part B Influenza Billing	07/30/2007	5511
R1255CP	05/25/2007	Guidelines for Payment of Diabetes Self-Management Training DSMT)	07/02/2007	5433

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R1217CP	03/30/2007	Update to Internet Only Manual (IOM) Publication 100-04, Chapter 18, Section 60.1	07/02/2007	5541
R1160CP	01/19/2007	Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change	07/02/2007	5387
R1158CP	01/19/2007	Guidelines for Diabetes Self-Management Training (DSMT) – Replaced by Transmittal 1255	07/02/2007	5433
R1117CP	11/24/2006	Reporting of Type of Bill (TOB) 12X for Billing of Diagnostic Mammographies	04/02/2007	5377
R1113CP	11/17/2006	Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)	01/02/2007	5235
R1111CP	11/09/2006	Clarification on Billing for Cryosurgery of the Prostate Gland	04/02/2007	5376
R1070CP	09/29/2006	New Current Procedural Terminology (CPT) Mammography Codes Sensitive	01/02/2007	5327
R1062CP	09/22/2006	Termination of Healthcare Common Procedure Coding System (HCPCS) Code G0107, Colorectal Cancer Screening, Fecal Occult Blood Test (FOBT), 1-3 Simultaneous Determinations	01/02/2007	5292
R1051CP	09/08/2006	Claims Submission Instructions for Institutional Providers Billing Vaccine Claims In Cases Where a National Provider Identifier (NPI) is Not Available	05/23/2007	4239

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R1014CP	07/28/2006	Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) Sensitive/Controversial	01/02/2007	5235
R1004CP	07/21/2006	Non-Application of Deductible for Colorectal Cancer Screening Tests	01/02/2007	5127
R921CP	04/28/2006	Reporting Diagnosis Code V06 6 on Influenza Virus and/or Pnuemococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 For Reporting Influenza Virus Vaccine	10/02/2006	5037
R916CP	04/28/2006	Correct Reporting of Diagnosis Codes on Screening Mammography Claims	10/02/2006	5050
R913CP	04/21/2006	Mammography Quality Standard Act (MQSA) File	07/07/2006	4396
R905CP	04/14/2006	Mammography Quality Standard Act (MQSA) File	05/15/2006	4396
R895CP	03/24/2006	Expansion of Glaucoma Screening Services	04/03/2006	4365
R890CP	03/17/2006	Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration	07/03/2006	4240
R844CP	02/10/2006	Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration	03/17/2006	4240

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R829CP	02/02/2006	Roster Billing for Mass Immunizers Billing for Inpatient Part B Services (Type of Bills (TOB) 12X and 22X)	07/03/2006	4242
R828CP	02/02/2006	Mammography Facility Certification File – Updated Procedures and Content	07/03/2006	4303
R827CP	02/01/2006	Use of 12X Type of Bill (TOB) for Billing Screening Mammography, Screening Pelvic Examinations, and Screening Pap Smears	07/03/2006	4243
R821CP	02/01/2006	Billing and Payment of Certain Colorectal Cancer Screening for Non-Patients Type of Bill (TOB) 14X	07/03/2006	4272
R795CP	12/30/2005	Redefined Type of Bill (TOB) 14X for Non-Patient Laboratory Specimens-CR 3835 Manualization	04/03/2006	4208
R705CP	10/07/2005	Modification to Reporting of Diagnosis Codes for Screening Mammography Claims	07/05/2005	3562
R681CP	09/16/2005	Guidelines for Payment of Vaccines (Pneumococcal Pneumonia Virus (PPV), Influenza Virus, and Hepatitis B Virus) and Their Administration Provided by Indian Health Service (IHS)/Tribally Owned and/or Operated Hospitals and Hospital Based Facilities	01/03/2006	3967
R634CP	08/03/2005	Guidelines for Payment of Vaccines (Pneumococcal Pneumonia Virus (PPV), Influenza Virus, and Hepatitis B Virus) and Their Administration at Renal Dialysis Facilities (RDFs)	01/03/2006	3936
R633CP	08/03/2005	Guidelines for Payment of Vaccines (Pneumococcal Pneumonia Virus (PPV), Influenza Virus, and Hepatitis B	01/03/2006	3967

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		Virus) and Their Administration Provided by Indian Health Service (IHS)/Tribally Owned and/or Operated Hospitals and Hospital Based Facilities		
R610CP	07/22/2005	Guidelines for Payment of Vaccines (Pneumococcal Pneumonia Virus (PPV), Influenza Virus, and Hepatitis B Virus) and Their Administration at Renal Dialysis Facilities (RDFs)	01/03/2006	3936
R544CP	04/29/2005	Modification of FISS Edits for Colorectal Cancer Screening Services (HCPCS Codes G0104, G0106, G0107, G0120, and G0328) Furnished at Skilled Nursing Facilities (SNFs)	10/03/2005	3763
R542CP	04/29/2005	Roster Billing for Mass Immunizers Billing for Inpatient Part B Services (Type of Bills (TOB) 12X and 22X)	10/03/2005	3735
R525CP	04/15/2005	Flu/PPV	N/A	3733
R519CP	04/08/2005	Flu/PPV	N/A	3733
R516CP	04/01/2005	OPPS Hospitals Billing for Initial Preventive Physical Exam (IPPE)	10/03/2005	3771
R482CP	02/18/2005	Manualization of Payment Change for Diagnostic Mammography and Diagnostic Computer Aided Detection	N/A	3662
R473CP	02/11/2005	Use of 12X Type of Bill (TOB) for Billing Vaccines and Their Administration	07/05/2005	3618
R457CP	01/28/2005	Diabetes Screening Tests	04/04/2005	3677
R440CP	01/21/2005	Updating the Common Working File Editing for Pap Smear (Q0091) and Adding a New Low Risk Diagnosis	07/05/2005	3659

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		Code (V72 31) for Pap Smear and Pelvic Examination		
R426CP	01/14/2005	Modification to Reporting of Diagnosis Codes for Screening Mammography Claims	07/05/2005	3562
R417CP	12/22/2004	Initial Preventive Physical Examination (IPPE)	01/03/2005	3638
R408CP	12/17/2004	Cardiovascular Disease Screening	01/03/2005	3411
R371CP	11/19/2004	Updated Billing Instruction for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)	04/04/2005	3487
R337CP	10/29/2004	Change in Hospital Type of Bill for Billing Diagnostic and Screening Mammographies	04/04/2005	3469
R298CP	09/10/2004	For carriers, reason codes and remark codes have been added to the IOM for more interpretations	09/25/2004	2617
R295CP	09/03/2004	For carriers, reason codes and remark codes have been added to the IOM for more interpretations	09/25/2004	2617
R260CP	07/30/2004	Billing for Cryosurgery of the Prostate	01/03/2005	3168
R214CP	06/25/2004	For carriers, reason codes and remark codes have been added to the IOM for more interpretations	09/25/2004	2617
R080CP	02/06/2004	Extended Medicare Coverage for Certain Colorectal Cancer Screenings at Skilled Nursing Facilities (SNFs)	07/06/2004	2874
R060CP	01/09/2004	New CAD codes for film and digital mammography services	N/A	2632

Rev #	Issue Date	Subject	Implementation Date	CR#
R052CP	12/19/2003	Expanded Medicare coverage for screening for early detection of colorectal cancer by adding an additional fecal occult blood test (iFOBT, immunoassay-based) that can be used as an alternative to the existing gFOBT, guaiac-based test	01/05/2004	2996
R040CP	12/08/2003	New ICD-9 Code V04 81 for billing the influenza virus vaccine benefit	N/A	2763
R033CP	11/28/2003	MQSA File Record Layout for the FDA Certified Digital Mammography Center	N/A	1729
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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