

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

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1 - Medicare Preventive and Screening Services

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

The Patient Protection and Affordable Care Act (ACA) amended the definition of “Preventive Services” available in Medicare and included two additional preventive physical examination services: the initial preventive physical examination (IPPE) and the annual wellness visit (AWV).

The definition of preventive services and the corresponding table of services are reflective of preventive services available in Medicare as of January 1, 2011.

1.1 - Definition of Preventive Services

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

Section 4104 of the ACA revised section 1861(ddd) of the Social Security Act (the Act) to add subsection (3), which defines the term “preventive services” as follows:

- The specific services currently listed in section 1861(ww)(2) of the Act with the explicit exclusion of electrocardiograms (as specified in section 1861(ww)(2)(M) of the Act).
- The Initial Preventive Physical Examination (IPPE), also known as the “Welcome to Medicare” Preventive Examination, established by section 611 of the MMA; and
- The Annual Wellness Visit (AWV), including Personalized Prevention Plan Services (PPPS), as specified by section 1861(hhh) of the Act, as added by section 4103 of the ACA.
- Additional preventive services identified for coverage through the national coverage determination (NCD) process.

(Refer to the CMS Web site at http://www.cms.gov/ncd/index_list.asp?list_type=nca for current NCD information).

1.2 – Table of Preventive and Screening Services

(Rev. 3711, Issued: 02-03-17; Effective: 07-01-17; Implementation: 07-03-17)

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	*Not Rated	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) furnished prior to January 1, 2017	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	B	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) furnished on or after January 1, 2017	76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	B	WAIVED
Cardiovascular Disease Screening	80061	Lipid panel	A	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	B	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	*Not Rated	WAIVED
Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	*Not Rated	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	B	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	B	WAIVED
	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	A	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	A	WAIVED
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	A	WAIVED
	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	A	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	A	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	A	WAIVED
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	A	WAIVED
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED
	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	A	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	B	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	B	WAIVED
	77063	Screening digital breast tomosynthesis, bilateral		WAIVED
	G0202	Screening mammography, producing direct 2-D digital image, bilateral, all views		WAIVED
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	B	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77083	Radiographic absorptiometry (e.g., photo densitometry, radiogrammetry), 1 or more sites		WAIVED
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED
<p>NOTE: For Colorectal Cancer Screening, effective January 1, 2015, when anesthesia service 00810 is performed in conjunction with screening colonoscopy services G0105 or G0121, coinsurance and deductible will be waived for anesthesia service 00810 when modifier 33 is entered on the anesthesia claim.</p> <p>When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia code 00810 should be submitted with only the PT modifier and only the deductible will be waived.</p>				
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	A	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	*Not Rated	Coins. Applies & Ded. is waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.	A	Coins. Applies & Ded. is waived
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk		WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	D	Not Waived
	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	I	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived
Influenza Virus Vaccine	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	B	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use		WAIVED
	90654	Influenza virus vaccine, split virus, preservative free, for intradermal use, for adults ages 18-64		WAIVED
	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED
	90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use		WAIVED
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90672	Influenza virus vaccine, live, quadrivalent, for intranasal use		WAIVED
	90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90674	Influenza virus vaccine, quadrivalent (ccIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use		WAIVED
	90682	<i>Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use</i>		<i>WAIVED</i>
	90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6- 35 months of age, for intramuscular use		WAIVED
	90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED
Pneumococcal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	B	WAIVED
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Hepatitis B Vaccine	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	A	WAIVED
	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use		WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	G0010	Administration of Hepatitis B vaccine	A	WAIVED
Hepatitis C Virus Screening	G0472	Screening for Hepatitis C antibody	B	WAIVED
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple- step method, HIV-1 or HIV-2, screening	A	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0433	Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED
	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV- 2 , screening		WAIVED
Smoking Cessation for services furnished prior to October 1, 2016	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	A	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Smoking Cessation for services furnished on or after October 1, 2016	99406	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	A	WAIVED
	99407	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	*Not Rated	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0439	Annual wellness visit, including PPPS, subsequent visit		WAIVED
Intensive Behavioral Therapy for Obesity	G0447	Face-to-Face Behavioral Counseling for Obesity, 15 minutes	B	WAIVED
	G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)		
Lung Cancer Screening	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)	B	WAIVED
	G0297	Low dose CT scan (LDCT) for lung cancer screening		

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, AWW 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(w)(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 AWW.

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 AWW. 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, and Hepatitis B Vaccines

(Rev. 3615, Issued: 09-23-16, Effective: 12-27-16, Implementation: 12-27-16)

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

Part B deductible and coinsurance do not apply for pneumococcal, influenza, and hepatitis virus vaccine.

State laws governing who may administer pneumococcal and influenza virus vaccinations and how the vaccines may be 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. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Pneumococcal vaccine, influenza virus vaccine, and hepatitis B vaccine 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 vaccine, hepatitis B vaccine, and influenza virus vaccine.

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. 1, 10-01-03)

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.

See the Medicare Benefit Policy Manual, Chapter 15, for additional coverage requirements for hepatitis B vaccines to high risk and intermediate risk groups.

10.2 - Billing Requirements

(Rev. 3621, Issued: 10-07-16, Effective: 10-01-16, Implementation: 10-03-16)

A Edits Not Applicable to Pneumococcal or Influenza Virus Vaccine Bills and Their 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 or influenza virus 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 or influenza virus vaccinations. If the provider knows or has reason to believe that a particular group health plan covers pneumococcal or influenza virus vaccine 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 or influenza virus vaccines. However, first claim development is performed if other services are submitted along with pneumococcal or influenza virus 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 MACs for these vaccines:

Hospitals;

Critical Access Hospitals (CAHs);

Skilled Nursing Facilities (SNFs);

Home Health Agencies (HHAs);

Hospices;

Comprehensive Outpatient Rehabilitation Facilities (CORFs); and

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

Other billing entities that may submit institutional claims are:

Independent Renal Dialysis Facilities (RDFs).

All providers submit institutional claims for hepatitis B. Providers other than independent RHCs and freestanding FQHCs submit institutional claims for influenza virus and pneumococcal vaccinations. (See §10.2.2.2 of this chapter for special instructions for independent RHCs and freestanding FQHCs.)

Institutional providers, other than independent RHCs and freestanding FQHCs, 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 the influenza virus vaccine, the pneumococcal vaccine, and/or the hepatitis B 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 Vaccine 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 pneumococcal and hepatitis B billing using pneumococcal and hepatitis B HCPCS codes.

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

(Rev. 3711, Issued: 02-03-17; Effective: 07-01-17; Implementation: 07-03-17)

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

HCPCS	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;
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
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent, 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
90682	<i>Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use</i>
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
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use 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.

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

HCPCS Definition

G0008	Administration of influenza virus vaccine;
G0009	Administration of pneumococcal vaccine; and
*G0010	Administration of hepatitis B vaccine.
*90471	Immunization administration. (For OPPS hospitals billing for the hepatitis B vaccine administration)
*90472	Each additional vaccine. (For OPPS hospitals billing for the hepatitis B vaccine administration)

*** NOTE:** For claims with dates of service prior to January 1, 2006, OPPS and non-OPPS hospitals report G0010 for hepatitis B vaccine administration. For claims with dates of service January 1, 2006 until December 31, 2010, OPPS hospitals report 90471 or 90472 for hepatitis B vaccine administration as appropriate in place of G0010. 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.

One of the following diagnosis codes must be reported as appropriate. 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-9-CM Diagnosis Code	Description
V03.82	Pneumococcus
V04.81**	Influenza
V06.6***	Pneumococcus and Influenza

****Effective for influenza virus claims with dates of service October 1, 2003 and later.**

*****Effective October 1, 2006, providers may report ICD-9-CM diagnosis code V06.6 on claims for pneumococcus and/or influenza virus vaccines when the purpose of the visit was to receive both vaccines.**

NOTE: ICD-10-CM diagnosis code Z23 may be used for an encounter for immunizations effective *October 1, 2015, when ICD-10 was implemented.*

If a diagnosis code for pneumococcus, hepatitis B, or influenza virus vaccination is not reported on a claim, contractors may not enter the diagnosis on the claim. Contractors must follow current resolution processes for claims with missing diagnosis codes.

If the diagnosis code and the narrative description are correct, but the HCPCS code is incorrect, the A/B MAC (A or B) may correct the HCPCS code and pay the claim. For example, if the reported diagnosis code is V04.81 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 80.3.2.1.1 (A/B MAC (B) Data Element Requirements) for claims submitted without a HCPCS code.

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

- UPIN code SLF000 to be reported on claims submitted prior to May 23, 2008, when Medicare began accepting NPIs, only
- The provider's own NPI to be reported in the NPI field for the attending physician on claims submitted on or after May 23, 2008, when NPI requirements were implemented.

10.2.2 - Claims Submitted to MACs Using Institutional Formats (Rev. 3621, Issued: 10-07-16, Effective: 10-01-16, Implementation: 10-03-16)

The applicable types of bill acceptable when billing for influenza virus and pneumococcal vaccines are 012x, 013x, 022x, 023x, 034x, 072x, 075x, 081x, 082x, 083x and 085x.

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 and hepatitis B 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, and Hepatitis B Virus Vaccines and Their Administration on Institutional Claims

(Rev. 3711, Issued: 02-03-17; Effective: 07-01-17; Implementation: 07-03-17)

Payment for Vaccines

Payment for these vaccines is as follows:

Facility	Type of Bill	Payment
Hospitals, other than Indian Health Service (IHS) Hospitals and Critical Access Hospitals (CAHs)	012x, 013x	Reasonable cost
IHS Hospitals	012x, 013x, 083x	95% of AWP
IHS CAHs	085x	95% of AWP
CAHs	085x	Reasonable cost
Method I and Method II Skilled Nursing Facilities	022x, 023x	Reasonable cost
Home Health Agencies	034x	Reasonable cost
Hospices	081x, 082x	<i>95% of AWP</i>
Comprehensive Outpatient Rehabilitation Facilities	075x	95% of the AWP
Independent Renal Dialysis Facilities	072x	95% of the AWP
Hospital-based Renal Dialysis Facilities	072x	Reasonable cost

Payment for Vaccine Administration

Payment for the administration of influenza virus and pneumococcal vaccines is as follows:

Facility	Type of Bill	Payment
Hospitals, other than IHS Hospitals 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, 083x	MPFS
IHS CAHs	085x	MPFS
CAHs	085x	Reasonable cost
Method I and II		
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

Payment for the administration of hepatitis B vaccine is as follows:

Facility	Type of Bill	Payment
Hospitals other than IHS hospitals 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, 083x	MPFS
CAHs	085x	Reasonable cost
Method I and II		
IHS CAHs	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

**10.2.2.2 - Special Instructions for Independent and Provider-Based
Rural Health Clinics/Federally Qualified Health Center (RHCs/FQHCs)**
(Rev. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Independent and provider-based RHCs and FQHCs do not include charges for influenza virus and pneumococcal vaccines on Form CMS-1450. Administration of these vaccines does not count as a visit when the only service involved is the administration of influenza virus and/or pneumococcal vaccine(s). If there was another reason for the visit, the RHC/FQHC should bill for the visit without adding the cost of the influenza virus and pneumococcal vaccines to the charge for the visit on the bill. AB MACs (A) pay at the time of cost settlement and adjust interim rates to account for this additional cost if they determine that the payment is more than a negligible amount.

Payment for the hepatitis B vaccine is included in the all-inclusive rate. However, RHCs/FQHCs do not bill for a visit when the only service involved is the administration of the hepatitis B vaccine. As with other vaccines administered during an otherwise payable encounter, no line items specifically for this service are billed on the RHC/FQHC claims in addition to the encounter.

10.2.3 - Institutional Claims Submitted by Home Health Agencies and Hospices

(Rev. 3621, Issued: 10-07-16, Effective: 10-01-16, Implementation: 10-03-16)

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, or hepatitis B), 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, or hepatitis B) 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, or

hepatitis B) 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, and hepatitis B 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. 3711, Issued: 02-03-17; Effective: 07-01-17; Implementation: 07-03-17)

MACs processing institutional claims pay for pneumococcal, influenza virus, and hepatitis B virus 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 influenza virus, *hepatitis B virus*, and pneumococcal 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. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

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 injectables 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 A/B MAC (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 nondialysis purposes are paid under hospital outpatient PPS rules.

10.2.5 - Claims Submitted to A/B MACs (B)

(Rev. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Medicare does not require that the influenza virus vaccine be administered under a physician's order or supervision. Effective for claims with dates of service on or after July 1, 2000, Medicare does not require that pneumococcal vaccinations be administered under a physician's order or supervision. Medicare still requires that the hepatitis B vaccine be administered under a physician's order with supervision. As a physician order is still required for claims for hepatitis B vaccinations, information on the ordering and/or referring physician must be entered on the claim.

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

A/B MACs (B) use specialty code 60 (Public Health or Welfare Agencies (Federal, State, and Local)) for Public Health Service Clinics (PHCs).

A/B MACs (B) use specialty code 73 (Mass Immunization Roster Billers) for centralized billers and specialty code 87 for pharmacists (all other suppliers (drug stores, department stores)).

Entities and individuals other than PHCs and pharmacists use the CMS specialty code that best defines their provider type. A list of specialty codes can be found in 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 and pneumococcal vaccinations in a mass immunization setting (including centralized flu

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 - A/B MAC (B) Indicators for the Common Working File (CWF)

(Rev. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

The A/B MAC (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	“0”	80 percent	“0”	Deductible applies	"1"

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 or influenza virus vaccine. AB MACs (B) use a “1” in the type of service field which indicates medical care for a hepatitis B vaccine.

10.2.5.2 - A/B MAC (B) Payment Requirements

(Rev. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Payment for pneumococcal, influenza virus, and hepatitis B vaccines follows the same standard rules that are applicable to any injectable drug or biological. (See chapter 17 for procedures for determining the payment rates for pneumococcal and influenza virus 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 of influenza virus and pneumococcal 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 reimbursed at the same rate as HCPCS code 90782 on the MPFS for the year that corresponded to the date of service of the claim.

Prior to March 1, 2003, HCPCS codes G0008, G0009, and G0010 are reimbursed at the same rate as HCPCS code 90471. 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.

A/B MACs (B) may not apply the limiting charge provision for pneumococcal, influenza virus vaccine, or hepatitis B vaccine and their administration in accordance with §§1833(a)(1) and 1833(a)(10)(A) of the Social Security Act (the Act.) The administration of the influenza virus vaccine is covered in the influenza virus vaccine benefit under §1861(s)(10)(A) of the Act, 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, and influenza virus vaccines administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

10.3 - Simplified Roster Claims for Mass Immunizers **(Rev. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)**

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass pneumococcal and influenza virus 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. Roster billing is not available for hepatitis B vaccinations.

Properly licensed individuals and entities conducting mass immunization programs may submit claims using a simplified claims filing procedure known as roster billing to bill for the influenza virus vaccine benefit for multiple beneficiaries if they agree to accept assignment for these claims. They may not collect any payment from the beneficiary. Effective November 1, 1996, roster billing is also available to individuals and entities billing for pneumococcal vaccinations.

Effective July 1, 1998, immunization of at least five beneficiaries on the same date is no longer required for any individual or entity to qualify for roster billing to A/B MACs (B). However, the rosters should not be used for single patient claims and the date of service for each vaccination administered must be entered.

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 or influenza virus 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.”

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 and/or influenza virus vaccines and their administration. In addition, claims submitted by the provider type “Mass Immunization Roster Biller” are always reimbursed at the assigned payment rate.

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. A/B MACs (B) must ensure that the software is as user friendly as possible for the pneumococcal and influenza virus vaccine benefits.

C. Medicare Advantage Plans Processing Requirements

Medicare Advantage Plans may use roster billing only if vaccinations are the only Medicare-covered services furnished by the Medicare Advantage Plans to Medicare

patients who are not members of the Medicare Advantage Plans. Medicare Advantage Plans must use Place of Service (POS) code 60 for processing roster claims.

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

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 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 and influenza virus vaccination claims.

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

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

A/B MACs (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 A/B MACs (B) must replicate the claim for each beneficiary listed on the roster.

A/B MACs (B) must provide Palmetto-Railroad Retirement Board (RRB) with local pricing files for pneumococcal and influenza virus vaccine and their administration. If PHCs or other individuals or entities inappropriately bill pneumococcal or influenza virus vaccinations using the roster billing method, A/B MACs (B) return the claim to the provider with a cover letter explaining why it is being returned and the criteria for the roster billing process. A/B MACs (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 claims to A/B MACs (B) must complete the following blocks on a single modified Form CMS-1500, which serves as the cover document for the roster for each facility where services are furnished. In order for A/B MACs (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 #	Instruction
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 9 if ICD-9-CM or 0 if ICD-10-CM is applicable. 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: Pneumococcal vaccine: "90732" or Influenza Virus vaccine: "Select appropriate influenza virus vaccine code" Line 2: Pneumococcal vaccine Administration: "G0009" or Influenza Virus Vaccine Administration: "G0008"
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).
Item 32a:	Enter the NPI of the service facility.
Item 33:	(Physician's, Supplier's Billing Name): The entity must complete this item to include the Provider Identification Number (not the Unique Physician Identification Number) or NPI when required.
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 which contains the variable claims information regarding the supplier of the service and

individual beneficiaries. While qualifying entities must use the modified Form CMS-1500 without deviation, A/B MACs (B) must work with these entities to develop a mutually suitable roster that contains the minimum data necessary to satisfy claims processing requirements for these claims. A/B MACs (B) must key information from the beneficiary roster list and abbreviated Form CMS-1500 to process pneumococcal and influenza virus vaccination claims.

The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;

NOTE: Although physicians who provide pneumococcal or influenza virus vaccinations may roster bill if they vaccinate fewer than five beneficiaries per day, they must include the individual date of service for each beneficiary's vaccination on the roster form.

- Control number for A/B MAC (B);
- Patient's health insurance claim 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 claim form 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.

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

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

The CMS currently authorizes a limited number of providers to centrally bill for influenza virus and pneumococcal immunization claims. 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.

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are 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 and the contractor must verify this through the enrollment process.

Centralized billers must send all claims for influenza virus and pneumococcal immunizations to a single contractor 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. This process is only available for claims for the influenza virus and pneumococcal 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 virus and pneumococcal vaccinations and 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 bill for these claims to their regular A/B MAC (B) per the instructions in §10.3.1 of this chapter.

The claims processing instructions in this section apply only to the designated processing contractor. However, all A/B MACs (B) must follow the instructions in §10.3.1.1.J, below, “Provider Education Instructions for All A/B MACs (B).”

A. Processing Contractor

The CMS central office will notify centralized billers of the appropriate contractor to bill when they receive their notification of acceptance into the centralized billing program.

B. Request for Approval

Approval to participate in the CMS centralized billing program is a two part approval process. Individuals and corporations who wish to enroll as a CMS mass immunizer centralized biller must send their request in writing. CMS will complete Part 1 of the

approval process by reviewing preliminary demographic information included in the request for participation letter. Completion of Part 1 is not approval to set up vaccination clinics, vaccinate beneficiaries, and bill Medicare for reimbursement. All new participants must complete Part 2 of the approval process (Form CMS-855 Application) before they may set up vaccination clinics, vaccinate Medicare beneficiaries, and bill Medicare for reimbursement. If an individual or entity's request is approved for centralized billing, the approval is limited to 12 months from September to August 31 of the next year. It is the responsibility of the centralized biller to reapply for approval each year. The designated contractor shall provide in writing to CMS and approved centralized billers notification of completion and approval of Part 2 of the approval process. The designated contractor may not process claims for any centralized biller who has not completed Parts 1 and 2 of the approval process. If claims are submitted by a provider who has not received approval of Parts 1 and 2 of the approval process to participate as a centralized biller, the contractor must return the claims to the provider to submit to the A/B MAC (B) for payment.

C. Notification of Provider Participation to the Processing Contractor

Before September 1 of every year, CMS will provide the designated contractor with the names of the entities that are authorized to participate in centralized billing for the 12 month period beginning September 1 and ending August 31 of the next year.

D. Enrollment

Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the processing contractor for centralized billing through completion of the Form CMS-855 (Provider Enrollment Application). Providers/suppliers are encouraged to apply to enroll as a centralized biller early as possible. Applicants who have not completed the entire enrollment process and received approval from CMS and the designated contractor to participate as a Medicare mass immunizer centralized biller will not be allowed to submit claims to Medicare for reimbursement.

Whether an entity enrolls as a provider type "Mass Immunization Roster Biller" or some other type of provider, all normal enrollment processes and procedures must be followed. Authorization from CMS to participate in centralized billing is dependent upon the entity's ability to qualify as some type of Medicare provider. In addition, as under normal enrollment procedures, the contractor must verify that the entity is fully qualified and certified per state requirements in each state in which they plan to operate.

The contractor will activate the provider number for the 12-month period from September 1 through August 31 of the following year. If the provider is authorized to participate in the centralized billing program the next year, the contractor will extend the activation of the provider number for another year. The entity need not re-enroll with the contractor every year. However, should there be changes in the states in which the entity plans to operate, the contractor will need to verify that the entity meets all state certification and licensure requirements in those new states.

E. Electronic Submission of Claims on Roster Bills

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.

F. 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 (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.

G. 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.

In order to pay claims correctly for centralized billers, the designated contractor must have the correct name and address, including ZIP code, of the entity 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 of influenza virus and pneumococcal vaccines 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 virus and pneumococcal benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination.

H. 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.

I. Provider Education Instructions for the Processing Contractor

The processing contractor must fully educate the centralized billers on the processes for centralized billing as well as for roster billing. General information on influenza virus and pneumococcal coverage and billing instructions is available on the CMS Web site for providers.

J. Provider Education Instructions for All A/B MACs (B)

By April 1 of every year, all A/B MACs (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 the central office address below. A/B MACs (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 centralized billing must contact CMS central office, in writing, at the following address by June 1 of the year they wish to begin centrally billing.

Center for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing Group
7500 Security Boulevard
Mail Stop C4-10-07
Baltimore, Maryland 21244

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 immunization services for influenza virus and pneumococcal 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). Since there is no coinsurance or deductible for the influenza virus and pneumococcal benefit, 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, health insurance number, date of birth, sex, and signature. [Fill in name of contractor] 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 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 contractor. Beneficiaries are sometimes confused when they receive an MSN from a contractor other than the contractor that normally processes their claims which results in unnecessary beneficiary inquiries to the Medicare contractor. Therefore, centralized billers must provide every beneficiary receiving an influenza virus or pneumococcal vaccination with the name of the processing contractor. 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. [Fill in name of contractor] 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 [Fill in name of contractor]. This can be done by completing the Form CMS-855 (Provider Enrollment Application), which can be obtained from [Fill in name of contractor].
- If an individual or entity's request for centralized billing is approved, the approval is limited to the 12 month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. Claims will not be processed for any centralized biller without permission from CMS.
- Each year the centralized biller must contact [Fill in name of contractor] 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. The approximate dates for when the vaccinations will be given;
 4. A list of the states in which influenza virus and pneumococcal clinics will be held;
 5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse);
 6. Whether the nurses who will administer the influenza virus and pneumococcal vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza virus and pneumococcal vaccinations;
 7. Names and addresses of all entities operating under the corporation's application;
 8. Contact information for designated contact person for centralized billing program.

10.3.2 - Claims Submitted to A/B MACs (A) for Mass Immunizations of Influenza Virus and Pneumococcal Vaccinations (Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

Some potential "mass immunizers," such as hospital outpatient departments and HHAs, have expressed concern about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to increase the number of beneficiaries who obtain needed preventive immunizations, simplified (roster) billing procedures are available to mass immunizers. The simplified (roster) claims filing procedure has been expanded for the pneumococcal vaccine. A mass immunizer is defined as any entity that gives the influenza virus vaccine or pneumococcal vaccine 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) 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 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 number;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;
- Patient health insurance claim 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 vaccine 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-9-CM** - V03.82 for the pneumococcal vaccine or V04.8 for Influenza Virus vaccine (Principal Diagnosis Code). For influenza virus vaccine claims with dates of service October 1, 2003 and later, use diagnosis code V04.81.
- **ICD-10-CM** - Use Z23 for an encounter for immunization effective with the implementation of ICD-10.
- Influenza virus vaccines require:
 - the UPIN SLF000 on claims submitted before May 23, 2007, or
 - 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 the pneumococcal and influenza virus vaccines.

Contractors use the beneficiary roster list to generate claim records to process the pneumococcal vaccine 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 pneumococcal and influenza virus vaccines 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 Virus and Pneumococcal Vaccine Services by HHAs

(Rev. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

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. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

The following billing instructions apply to hospitals that roster bill for the influenza virus vaccine and the pneumococcal vaccine 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. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

As for all other Medicare-covered services, AB MACs (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, AB MACs (A) must offer free, or at-cost, electronic billing software and ensure that the software is as user friendly as possible for the influenza virus vaccine benefit.

10.4 - CWF Edits

(Rev. 1617, Issued: 10-24-08, Effective: 04-06-09, Implementation: 04-06-09)

In order to prevent duplicate payments for influenza virus and pneumococcal vaccination claims by the A/B MAC (B) and the centralized billing contractor, effective for claims received on or after July 1, 2002, CWF has implemented a number of edits.

NOTE: 90659 was discontinued December 31, 2003.

CWF returns information in Trailer 13 information from the history claim. The following fields are returned to the contractor:

- Trailer Code;
- Contractor Number;
- Document Control Number;
- First Service Date;
- Last Service Date;
- Provider, Physician, Supplier Number;
- Claim Type;
- Procedure code;
- Alert Code (where applicable); and,
- More history (where applicable.)

10.4.1 - CWF Edits on A/B MAC (A) Claims

(Rev. 3711, Issued: 02-03-17; Effective: 07-01-17; Implementation: 07-03-17)

In order to prevent duplicate payment by the same A/B MAC (A), CWF edits by line item on the A/B MAC (A) number, the beneficiary Health Insurance Claim (HIC) number, and the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90674, **90682**, 90685, 90686, 90687, or 90688 and the pneumococcal procedure codes 90669, 90670, or 90732, and the administration codes G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90674, **90682**, 90685, 90686, 90687, or 90688 and it already has on record a claim with the same HIC number, same A/B MAC (A) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF rejects.

If CWF receives a claim with HCPCS codes 90669, 90670, or 90732 and it already has

on record a claim with the same HIC number, same A/B MAC (A) number, same date of service, and the same HCPCS code, the second claim submitted to CWF rejects when all four items match.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same HIC number, same A/B MAC (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 A/B MAC (A) a reject code “7262” for this edit. A/B MACs (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 A/B MAC (B) Claims

(Rev. 3711, Issued: 02-03-17; Effective: 07-01-17; Implementation: 07-03-17)

In order to prevent duplicate payment by the same A/B MAC (B), CWF will edit by line item on the A/B MAC (B) number, the HIC number, the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90674, **90682**, 90685, 90686, 90687, or 90688; the pneumococcal procedure codes 90669, 90670, or 90732; and the administration code G0008 or G0009.

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

If CWF receives a claim with HCPCS codes 90669, 90670, or 90732 and it already has on record a claim with the same HIC number, same A/B MAC (B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject when all four items match.

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

CWF will return to the A/B MAC (B) a specific reject code for this edit. A/B MACs (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 A/B MAC (B), CWF will edit by line item for A/B MAC (B) number, same HIC number, same date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90674, **90682**, 90685, 90686, 90687, or 90688; the pneumococcal procedure codes 90669, 90670, or 90732; and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90674, **90682**, 90685, 90686, 90687, or 90688 and it already has on record a claim with a **different** A/B MAC (B) number, but same HIC 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 90669, 90670, or 90732 and it already has on record a claim with the same HIC number, different A/B MAC (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 A/B MAC (B) number, but the same HIC number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return a specific reject code for this edit. A/B MACs (B) must deny the second claim. For the second edit, 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. 3711, Issued: 02-03-17; Effective: 07-01-17; Implementation: 07-03-17)

When CWF receives a claim from the A/B MAC (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 HIC number; the date of service; the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90674, **90682**, 90685, 90686, 90687, or 90688; the pneumococcal procedure codes 90669, 90670, or 90732; and the administration code G0008 or G0009.

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

10.5 - Medicare Summary Notice (MSN)

(Rev. 1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Contractors must generate a Medicare Summary Notice (MSN) for the pneumococcal, influenza virus, hepatitis B vaccines, and their administration.

For vaccines rendered to beneficiaries other than pneumococcal, influenza virus or hepatitis B, which are not covered by Medicare, they must send the following MSN message.

MSN: 18.2:

This immunization and/or preventive care is not covered.

The Spanish version of this MSN message should read:

Esta inmunización y/o servicios preventivos no están cubiertos.

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 35 th and 40 th 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 charge.

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.

20.1.3 - Using Certification Data in Claims Processing

20.2 - HCPCS and Diagnosis Codes for Mammography Services (Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

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

HCPCS Code	Definition
77051* (76082*)	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography (list separately in addition to code for primary procedure). Code 76082 is effective January 1, 2004 thru December 31, 2006. Code 77051 is effective January 1, 2007.
77052* (76083*)	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography (list separately in addition to code for primary procedure). Code 76083 is effective January 1, 2004 thru December 31, 2006. Code 77052 is effective January 1, 2007.
77055* (76090*)	Diagnostic mammography, unilateral.
77056* (76091*)	Diagnostic mammography, bilateral.
77057* (76092*)	Screening mammography, bilateral (two view film study of each breast).
77063**	Screening Breast Tomosynthesis; bilateral (list separately in addition to code for primary procedure).

HCPCS Code	Definition
G0202	Screening mammography, producing direct 2-D digital image, bilateral, all views. Code is effective April 1, 2001. This code descriptor is effective January 1, 2015.
G0204	Diagnostic mammography, direct 2-D digital image, bilateral, all views. Code is effective April 1, 2001. This code descriptor is effective January 1, 2015.
G0206	Diagnostic mammography, producing direct 2-D digital image, unilateral, all views. Code is effective April 1, 2001. This code descriptor is effective January 1, 2015.
G0279**	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206)

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

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76082, 76083, 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.

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 January 1, 1998

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-9-CM

V76.11 - “Special screening for malignant neoplasm, screening mammogram for high-risk patients” or;

V76.12 - “Special screening for malignant neoplasm, other screening mammography.”

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 V76.11 or V76.12 (ICD-9-CM) or 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 codes V76.11 or V76.12 (ICD-9-CM) or 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.

Diagnosis codes for a diagnostic mammography will vary according to diagnosis.

B. Diagnoses for Services October 1, 1997 Through December 31, 1997

On every screening mammography claim where the patient is not a high-risk individual, diagnosis code V76.12 is reported on the claim.

If the screening is for a high risk individual, the provider reports the principal diagnosis code as V76.11 - “Screening mammogram for high risk patient.”

In addition, for high-risk individuals, one of the following applicable diagnoses codes is reported as “Other Diagnoses codes”:

- V10.3 “Personal history - Malignant neoplasm female breast”;
- V16.3 “Family history - Malignant neoplasm breast”; or
- V15.89 “Other specified personal history representing hazards to health.”

The following chart indicates the ICD-9-CM diagnosis codes reported for each high-risk category:

High Risk Category	Appropriate Diagnosis Code
A personal history of breast cancer	V10.3
A mother, sister, or daughter who has breast cancer	V16.3
Not given birth prior to age 30	V15.89
A personal history of biopsy-proven benign breast disease	V15.89

20.2.1 - Computer-Aided Detection (CAD) Add-On Codes
(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Screening Add-on Codes 76085 and 77052* (76083*)

Effective for services on or after January 1, 2002 through December 31, 2003, (or April 1, 2002 for hospitals subject to OPPI) a new CPT code 76085, CAD conversion of standard film images to digital images has been established as an add-on code that can be billed only in conjunction with the primary service screening mammography code 76092. The definition of 76085 is: "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, mammography (list separately in addition to code for primary procedure)."

NOTE: For claims with dates of service April 1, 2003 - December 31, 2003, code G0202 may be billed in conjunction with 76085.

A/B MACs (A) and (B) make payment under the Medicare physician fee schedule. There is no Part B deductible. However, coinsurance is applicable.

For claims with dates of service April 1, 2005, and later, hospitals bill for code 76082* (77051*) under the 13X bill type. The 14X bill type is no longer applicable. Appropriate TOBs for providers other than hospitals are 22X, 23X, and 85X.

A/B MACs (A) and (B) must assure that claims containing code 76085 also contain HCPCS code 76092 or G0202. If not, A/B MACs (A) return claims to the provider with an explanation that payment for code 76085 cannot be made when billed alone. A/B MACs (B) deny payment for 76085 when billed without 76092 or G0202.

NOTE: When screening CAD 76085 is billed in conjunction with a screening mammography (76092 or G0202) and the screening mammography (76092 or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

Effective with claims with dates of service January 1, 2004 thru December 31, 2006, HCPCS code 76083, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service mammography code 76092 or G0202.

Effective with claims with dates of service January 1, 2007 and later, HCPCS code 77052, which replaces code 76083 "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service mammography code 77057 or G0202.

A/B MACs (A) and (B) must assure that claims containing code 77052* (76083*) also contain HCPCS code 77057* (76092*) or G0202. A/B MACs (A) return claims containing code 77052* (76083*) that do not also contain HCPCS code 77057* (76092*) or G0202 with an explanation that payment for code 77052* (76083*) cannot be made when billed alone. A/B MACs (B) deny payment for 77052* (76083*) when billed without 77057* (76092*) or G0202.

NOTE: When screening CAD 77052* (76083*) is billed in conjunction with a screening mammography (77057* (76092*) or G0202) and the screening mammography (77057* (76092*) or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76083 and 76092 or G0202. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77052 and 77057 or G0202, respectively.

Diagnostic Add-on Codes G0236 and 77051* (76082*)

Effective for services on or after January 1, 2002 thru December 31, 2003, (or April 1, 2002 for hospital claims subject to OPPS), HCPCS code G0236 was established for diagnostic mammography CAD that can be billed only on the same claim with the primary service of either 76090 or 76091. The definition of G0236 is: "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation." The code must be listed separately in addition to code for the primary procedure.

NOTE: For claims with dates of service April 1, 2003 - December 31, 2003, code G0204 and G0206 may be billed in conjunction with G0236.

For claims with dates of service April 1, 2005, and later, hospitals bill for code 76082* (77051*) under the 13X bill type. The 14X bill type is no longer applicable. Appropriate TOBs for providers other than hospitals are 22X, 23X, and 85X.

There are no frequency limitations on film or digital diagnostic tests or CAD-diagnostic tests.

A/B MACs (A) and (B) must assure that claims containing code G0236 also contain HCPCS code 76090, 76091, G0204, or G0206. If not, A/B MACs (A) return claims to the provider with an explanation that payment for code G0236 cannot be made when billed alone. A/B MACs (B) deny payment for G0236 when billed without 76090, 76091, G0204, or G0206.

Effective with claims with dates of service January 1, 2004 thru December 31, 2006, HCPCS code 76082, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service mammography code 76090, 76091, G0204, or G0206.

Effective for claims with dates of service January 1, 2007 and later, HCPCS code 77051, which replaces code 76082, “Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure),” can be billed in conjunction with the primary service mammography code 77055, 77056, G0204, or G0206.

A/B MACs (A) and (B) must assure that claims containing code 77051* (76082*) also contain HCPCS codes 77055*(76090*), 77056* (76091*), G0204 or G0206. A/B MACs (A) return claims containing code 77051* (76082*) that do not also contain HCPCS code 77055* (76090*), 77056* (76091*), G0204, or G0206 with an explanation that payment for code 77051* (76082*), cannot be made when billed alone. A/B MACs (B) deny payment for 77051* (76082*) when billed without 77055* (76090*), 77056* (76091*), G0204, or G0206.

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76090, 76091, G0204 or G0206 with 76082. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055, 77056, G0204, or G0206 with 77051, respectively.

20.2.1.1 - CAD Billing Charts

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

The following chart provides guidance for billing of CAD add-on codes. It reflects appropriate coding combinations that may be billed and the time frames associated with each.

Chart I - Screening CAD Codes

CAD Codes	Effective 01-01-02 thru 03-31-03	Effective 04-01-03 thru 12-31-03	Effective 01-01-04 thru 12-31-06	Effective 01-01-07 and later
76085	76092	76092, G0202	N/A	N/A
76083	N/A	N/A	76092, G0202	N/A
77052	N/A	N/A	N/A	77057, G0202

Chart II - Diagnostic CAD Codes

CAD Codes	Effective 01-01-02 thru 03-31-03	Effective 04-01-03 thru 12-31-03	Effective 01-01-04 thru 12-31-06	Effective 01-01-07 and later
G0236	76090	76090	N/A	N/A
	76091	76091		
		G0204		
		G0206		
76082	N/A	N/A	76090	N/A
			76091	N/A
			G0204	N/A
			G0206	N/A
77051	N/A	N/A	N/A	G0204
				G0206
				77055
				77056

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76090, 76091, G0204 or G0206 with 76082. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055, 77056, G0204, or G0206 with 77051, respectively.

The CWF Application of Age and Frequency Edits,--The following chart reflects proper application of CWF age and frequency edits applied to CAD HCPCS codes billed in conjunction with screening mammographies HCPCS codes.

CAD Codes	Effective 01-01-02 thru 03-31-03	Effective 04-01-03 thru 12-31-03	Effective 01-01-04 thru 12-31-06	Effective 01-01-07 and later
76085	76092	76092, G0202	N/A	N/A
76083	N/A	N/A	76092, G0202	N/A
77052	N/A	N/A	N/A	77057, G0202

See section 20.5.1, for A/B MACs (B) CWF edits

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76083 and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77052 and 77057 respectively.

20.2.2 -Digital Breast Tomosynthesis

(Rev. 3301, Issued: 08-06-15, Effective: 01-01-15, Implementation: 01-04-16)

A. Screening Breast Tomosynthesis

Effective for claims with dates of service January 1, 2015 and later, HCPCS code 77063, “Screening Digital Breast Tomosynthesis, bilateral, must be billed in conjunction with the primary service mammogram code G0202.

A/B MACs (A) and (B) must assure that claims containing code 77063 also contain HCPCS code G0202. A/B MACs (A) return claims containing code 77063 that do not also contain HCPCS code 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 G0202.

NOTE: When screening digital breast tomosynthesis, code 77063, is billed in conjunction with a screening mammography, code G0202, and the screening mammography 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, 2015 and later, HCPCS code G0279, “Diagnostic digital breast tomosynthesis, unilateral or bilateral”, must be billed in conjunction with the primary service mammogram code G0204 or G0206.

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.

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.

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

(Rev. 3536, Issued: 06-08-16, Effective: 07-01-16, Implementation: 07- 05-16- for MCS system changes; October 3, 2016- for FISS)

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 G0204 or G0206, contractors shall use the following messages:

CARC 107 - The related or qualifying claim/service was not identified on this claim.
Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

MSN 9.2 – This item or service was denied because information required to make payment was missing.

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

Group Code CO (Contractual Obligation) assigning financial liability to the provider.

When denying claim lines for HCPCS code 77063 because the provider is not certified to perform this service (Tomosynthesis (3-D) mammography), 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: 171
RARC: N762
MSN: 16.2
Group Code: CO

20.3 - Payment

(Rev. 1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

There is no Part B deductible for screening mammographies, however, coinsurance is applicable. 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 Prior to January 1, 2002

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Claims with dates of service prior to January 1, 2002, are subject to a payment limitation. The professional component is 32 percent of the total limit for the complete service. The technical component is 68 percent.

When the technical and professional components of the screening mammography are billed separately, the payment limit is adjusted to reflect either the professional or technical component only. That is, the limitation applicable to global billing for screening is allocated between the professional and technical components as set forth by regulations. Below are the limitation amounts applicable each calendar year:

Calendar Year	Global Payment Limit	Technical Component Amount	Professional Component Amount
1996	\$62.10	\$42.23	\$19.87
1997	\$63.34	\$43.07	\$20.27
1998	\$64.73	\$44.02	\$20.71
1999	\$66.22	\$45.03	\$21.19
2000	\$67.81	\$46.11	\$21.69
2001	\$69.23	\$47.08	\$22.15

NOTE: The CMS annually updates the overall limit annually by the percentage increase in the Medicare Economic Index.

EXAMPLE: In calendar year 2001, 32 percent of the \$69.23 limit, or \$22.15, is used in determining payment for the professional component; and 68 percent of the \$69.23 limit, or \$47.08, is used in determining payment for the technical component.

A/B MAC (A) Payment

Payment for the **technical component** equals 80 percent of the least of:

- The actual charge for the technical component (HCPCS code 77057* (76092*)) of the service;
- The physicians' fee schedule amount for the technical component of HCPCS code 77056* (76091*) (a bilateral diagnostic mammogram); or
- The technical portion of the screening mammography limit as identified in the chart above.

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76091 and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77056 and 77057 respectively.

A/B MACs (B) Payment - Technical Component

Payment for the **technical component** equals 80 percent of the least of:

- The actual charge for the technical component of the service;
- The amount determined with respect to the technical component for the service under Medicare Physicians' Fee Schedule; or
- The technical portion of the screening mammography limit as identified in the chart above.

A/B MACs (B) Payment - Professional Component

The amount of payment for the **professional** charge equals 80 percent of the least of:

- The actual charge for the professional component;
- The amount determined with respect to the professional component for the service under the Medicare Physician Fee Schedule; or
- The professional portion of the screening mammography limit based on the year of service according to the chart above.

A/B MAC (A) or (B) Payment - Global

The amount of payment for the **global charge** equals 80 percent of the least of:

- The actual charge for the procedure;
- The amount determined with respect to the global procedure under the Medicare Fee Schedule; or
- The limit for the procedure based on the year of service according to the chart above.

A/B MACs (B) may receive bills for global, professional, or technical components. If mammography services are furnished by nonparticipating physicians and suppliers, there is a special limiting charge. A/B MACs (B) must apply the appropriate payment reductions to screening mammography procedures furnished by new physicians.

Providers bill the technical component of mammography services to A/B MACs (A). Only a CAH may bill globally if the CAH elected the optional method of payment for mammography services furnished on or after January 1, 2002.

A/B MAC (A) Payment Example

\$90.00	Provider charges for HCPCS;
\$75.00	Physician' fee schedule amount; and
\$47.08	Technical portion of the screening mammography limit (68% of \$69.23 (year 2001))

Payment is 80 percent of the lower of the following amounts. To calculate the payment, select the lower of:

\$90.00	Provider charges;
\$75.00	Physician' fee schedule amount for the technical component; or
\$47.08	Technical portion of the screening mammography limit (year 2001).

Payment is 80 percent of the remainder. A/B MACs (A) do not apply the provider's interim rate. This is a final payment to the provider. In this example, payment is calculated as follows:

$$\$47.08 \times 80\% = \$ 37.66 \text{ payment to the provider}$$

To determine the patient's liability, multiply the actual charge by 20 percent. The result is the patient's liability. In this example, the calculation is:

$$\$90.00 \times 20\% = \$18.00 \text{ (coinsurance).}$$

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

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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 77057* (76092*) is equal to the lower of:

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

Program payment for the service is 80 percent of the lower amount and coinsurance is 20 percent. Part B deductible 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).

20.3.2.1 - Outpatient Hospital Mammography Payment Table (Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Payment for Mammography in the Hospital Outpatient PPS Setting. For all other hospitals, the effective date for column 1 is April 1, 2001, through December 31, 2001, and for column 2, the effective date is January 2002.

PAYMENT FOR SCREENING MAMMOGRAPHY

Screening Mammography (Revenue Code 403)	Year 2000	2001 (April 1, 01 thru March 31, 2002)	April 1, 2002 - forward
77057* (76092*) Screening Mammography, bilateral No deductible, Coinsurance applies	Lesser of: 1. Charges, 2. TC of PFS for 76091, or 3. Annual payment limit	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. Annual payment limit \$47.08	Lesser of: 1. Charge, or 2. TC of MPFS for code 77057* (76092*)
G0202 Screening Mammography, producing direct digital image, bilateral, all views. No deductible Coinsurance applies	N/A	Lesser of: 1. Charge, or 2. 150% TC of MPFS for code 76091	Lesser of: 1. Actual charge, or 2. TC of MPFS for code G0202
G0203 Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. No Deductible Coinsurance Applies	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. \$57.28 (annual \$ limit of \$47.08 plus \$10.20TC add on)	N/A

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76091 and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77056 and 77057 respectively.

PAYMENT FOR DIAGNOSTIC MAMMOGRAPHY

Diagnostic Mammography (Revenue Code 401)	Year 2000	April 1, 2001 thru March 31, 2002	April 1, 2002 thru December 31, 2004	January 1, 2005 - forward
77056* (76091*) Mammography, bilateral Deductible and coinsurance apply	OPPS (beginning Aug.1, 2000)	OPPS	OPPS	Lesser of charge or TC or the MPFS for 77056* (76091*)
77055* (76090*) Mammography, bilateral Deductible and coinsurance apply	OPPS (beginning Aug.1, 2000)	OPPS	OPPS	Lesser of charge or TC or the MPFS for 77055* (76090*)
G0204 Diagnostic Mammography, direct digital image, bilateral, all views Deductible and coinsurance apply	N/A	Lesser of: 1. Charge, or 2. 150% TC of MPFS for code 76091	OPPS	Lesser of charge or TC or the MPFS for G0204
G0206 Diagnostic Mammography, direct digital image, unilateral, all views Deductible and coinsurance apply	N/A	OPPS (same APC as 76090)	OPPS	Lesser of charge or TC or the MPFS for G0206

Diagnostic Mammography (Revenue Code 401)	Year 2000	April 1, 2001 thru March 31, 2002	April 1, 2002 thru December 31, 2004	January 1, 2005 - forward
G0205 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. \$57.28 (annual \$ limit of \$47.08 plus \$10.20TC add on)	N/A	N/A
G0207 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	OPPS (same APC as 76090)	N/A	N/A

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76090 and 76091. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055 and 77056 respectively.

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.

COMPUTER-AIDED DETECTION (CAD) DEVICES

Computer-aided Detection (CAD)	Year 2000	2001 (April 1 - Dec 31)	Year 2002 - 2003	January 1, 2004	January 1, 2005 - forward
76085* CAD with screening mammography (may bill with 76092) No deductible coinsurance applies	N/A	N/A	Lesser of: 1. Charge, or 2. TC of MPFS for code 76085	N/A	N/A
G0236* CAD with diagnostic mammography (may bill with 76090 or 76091) Deductible and coinsurance apply	N/A	N/A	OPPS	N/A	N/A
77052* (76083*) CAD with screening mammography (may bill with 77057* (76092*) or G0202) No deductible applies	N/A	N/A	N/A	Lesser of: 1. Charge, or 2. TC of MPFS for code 76083	Lesser of: 1. Charge, or 2. TC of MPFS for code 77052* (76083*)
77051* (76082*) CAD with diagnostic mammography (may bill with 77055* (76090*), 77056* (76091*), G0204, or G0206) Deductible and coinsurance apply	N/A	N/A	N/A	OPPS	Lesser of: 1.Charge, or 2.TC of MPFS for code 77051* (76082*)

TC = technical component

MPFS= Medicare Physician Fee Schedule

OPPS= Outpatient Prospective Payment System

APC= Ambulatory Payment Classification

* Code 76085 is a deleted code as of December 31, 2003. The code to be used for dates of service beginning January 1, 2004 thru December 31, 2006, is 76083. For claims with dates of service January 1, 2007 and later, the new code is 77052. Code G0236 is a deleted code as of December 31, 2003. The code to be used for dates of service beginning January 1, 2004 thru December 31, 2006, is 76082. For claims with dates of service January 1, 2007 and later, the new code is 77051.

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 CAD services. Medicare payment will be based on the MPFS. Payment will no longer be made under the OPPS.

20.3.2.2 - Payment for Computer Add-On Diagnostic and Screening Mammograms for A/B MACs (A) and (B)

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Payment for computer add-on **diagnostic** mammogram HCPCS code G0236 or 77051* (76082*) when billed with CPT code 77055* (76090*), 77056* (76091*), G0204, or G0206 is as follows:

Place/Provider of Service	Payment
Physician	Medicare physicians' fee schedule
Outpatient Hospital	Outpatient Prospective Payment System (OPPS)
Critical Access Hospital (CAH)	Reasonable Cost
SNF	Medicare physicians' fee schedule - technical component
Independent RHC	All-inclusive rate for professional component (codes 76090 and 76091)**
Freestanding FQHC	All-inclusive rate for professional component (codes 76090 and 76091)**

** Only for dates of service prior to April 1, 2005.

NOTE: Effective for claims with dates of service on or after January 1, 2005, computer add-on diagnostic mammography services provided in a hospital are paid under the MPFS. Payment is no longer made under the OPPS.

Code G0236, “Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography,” for CAD has been established as an add on code that can be billed in conjunction with primary service code G0204 or G0206, as well as existing codes 76090 or 76091. The Part B deductible and coinsurance apply. HCPCS code G0236 is deleted as of December 31, 2003.

Effective for claims with dates of service January 1, 2004 thru December 31, 2006, add-on HCPCS code 76082, “Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure),” can be billed in conjunction with primary service codes G0204 or G0206 as well as codes 76090 or 76091. The Part B deductible and coinsurance apply.

Effective for claims with dates of service January 1, 2007 and later, add-on HCPCS code 77051, “Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure),” can be billed in conjunction with primary service codes G0204 or G0206 as well as codes 77055 or 77056. The Part B deductible and coinsurance apply.

The add-on code cannot be billed alone. A/B MACs (A) return to provider claims containing only codes G0236 or 77051* (76082*) with an explanation that payment for code G0236 or 77051* (76082*) cannot be made when billed alone.

A/B MACs (B) deny the claim using remark code N122, “Mammography add-on code cannot be billed by itself” (effective September 12, 2002).

Payment for computer add-on **screening** mammogram HCPCS code 76085 or 77052* (76083*) when billed with CPT code 77057* (76092*) or G0202 is as follows:

Place/Provider of Service	Payment
Physician	Medicare physicians’ fee schedule
Outpatient Hospital	Medicare physicians’ fee schedule
Critical Access Hospital (CAH)	Reasonable Cost
SNF	Medicare physicians’ fee schedule - technical component
Independent RHC	All-inclusive rate for professional component (code 76092**)
Freestanding FQHC	All-inclusive rate for professional component (code 76092**)

** Only for dates of service prior to April 1, 2005.

Code 76085, “Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography,” for CAD has been established as an add on code that can be billed in conjunction with primary service code G0202 as well as 76092. HCPCS code 76085 is deleted as of December 31, 2003. The Part B Deductible does not apply. However, coinsurance is applicable. A/B MACs (A) use the benefit pricing file provided by CMS to pay the above codes where payment is based on the technical component of the Medicare physician fee schedule.

Effective for claims with dates of service January 1, 2004 thru December 31, 2006, HCPCS code 76083, “Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure),” can be billed in conjunction with the primary service code G0202 as well as code 76092. There is no Part B deductible but coinsurance applies.

Effective for claims with dates of service January 1, 2007 and later, HCPCS code 77052, “Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure),” can be billed in conjunction with the primary service code G0202 as well as code 77057. There is no Part B deductible but coinsurance applies.

The add-on code cannot be billed alone. A/B MACs (A) return to provider claims containing only codes 76085 or 77052* (76083*) with an explanation that payment for code 76085 or 77052* (76083*) cannot be made when billed alone.

A/B MACs (B) deny the claim using remark code N122 “Mammography add-on code cannot be billed by itself” (effective September 12, 2002).

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76082, 76083, 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.

20.3.2.3 - Critical Access Hospital Payment

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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 77057* (76092*). They also include the professional component on a separate line, with revenue code 96X, 97X, or 98X and HCPCS code 77057* (76092*).

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76083 and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77052 and 77057 respectively.

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 77057* (76092*).

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.

*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.

20.3.2.3.1 - CAH Screening Mammography Payment Table (Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Payment for Screening Mammography in the Critical Access Hospital Outpatient Setting

Method 1 (Standard)

	TOB	Rev Code	HCPCS	Payment
Services prior to cost reporting periods ending October 1, 2001 and services prior to July 1, 2001 (BIPA)				
Technical Component Deductible does not apply.	85X	403	76092	A/B MAC (A) payment is 80%

	TOB	Rev Code	HCPCS	Payment
Coinsurance based on charge.				of the reasonable cost.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.			76092	A/B MACs (B) payment is 80% of the lower of the charge or MPFS amount for the technical component.
Services on or after July 1, 2001 to January 1, 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	76092	A/B MAC (A) payment is 80% of the reasonable cost.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.			76092	A/B MACs (B) payment is 80% of the lower of the charge or MPFS amount.
Services on or after January 1 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	*76092 *76085 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.			*76092 *76085 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.

	TOB	Rev Code	HCPCS	Payment
*Codes must be billed together on the same claim. Also note that 76085 is deleted after December 31, 2003. Use code 76083 for claims with dates of service January 1, 2004 and later.				

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 for cost reporting periods on or after October 1, 2001 and service dates on or after July 1 and prior to January 1, 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	76092	A/B MAC (A) payment is 80% of the reasonable cost. (Interim rate times charge)
Professional Component Deductible does not apply. Coinsurance based on charge.	85X	96X, or 97X or 98X	76092	A/B MAC (A) payment is 115% of the lower of the charge or MPFS amount after coinsurance is deducted.
Professional Component service in a rural or urban HPSA area. Deductible does not apply. Coinsurance based on charge	85X	96X, or 97X or 98X	Modifier “-QB” or “-QU” for dates of service prior to January 1, 2006. For more information on HPSA modifiers see chapter 4, section 250.2.2 in Pub. 100-04.	If HPSA area, A/B MAC (A) payment is 115% of 110% of the lower of the charge or MPFS amount after coinsurance is deducted times 110%.
Services on or after January 1 2002				
Technical Component Deductible does not apply.	85X	403	*76085	A/B MAC (A) payment is 80% of the lower of

	TOB	Rev Code	HCPCS	Payment
Coinsurance based on charge.			77057* (76092*) G0202	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	*76085 77057* (76092*) G0202	A/B MAC (A) pays 115% of 80% (that is 92%) of the lower of the charge or the MPFS amount.
* Codes must be billed together on the same claim. Also note that 76085 is deleted after December 31, 2003. Use code 76083 for claims with dates of service January 1, 2004 thru December 31, 2006, and 77052 for claims with dates of service January 1, 2007 and later. Also, for claims with dates of service prior to January 1, 2007, CAHs report CPT code 76092. For claims of service with dates of service January 1, 2007 and later, CAHs report CPT code 77057.				

20.3.2.4 - SNF Mammography Payment Table

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Payment for Screening Mammography

Screening Mammography (Revenue Code 0403)	Year 2000	2001 (April 1 - March 31, 2002)	April 1, 2002 and later
77057* (76092*) Screening Mammography, bilateral No deductible, Coinsurance applies	Lesser of: 1. Charges or, 2. TC of MPFS 76091, or 3. Annual payment limit	Lesser of: 1. Charge or, 2. TC of MPFS for code 76091, or 3. Annual payment limit \$47.08	Lower of: 1. Charge, or 2. TC of MPFS for code 77057* (76092*)
G0202 Screening Mammography, producing direct digital image, bilateral, all views. No deductible Coinsurance applies	N/A	Lower of: 1. Charge, or 2. 150% TC of MPFS for code 76091	Lower of: 1. Charge, or 2. TC of MPFS for code G0202

Screening Mammography (Revenue Code 0403)	Year 2000	2001 (April 1 - March 31, 2002)	April 1, 2002 and later
G0203 Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. No Deductible Coinsurance Applies	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. \$57.28 (annual \$ limit of \$47.08 plus \$10.20TC add on)	N/A

* For claims with dates of service prior to January 1, 2007, SNFs report CPT codes 76091 and 76092. For claims with dates of service January 1, 2007 and later, SNFs report CPT codes 77056 and 77057 respectively.

Payment for Diagnostic Mammography

Diagnostic Mammography (Revenue Code 401)	Year 2000	2001 (April 1- March 31, 2002)	April 1, 2002 and later
77056* (76091*) Mammography, bilateral Deductible and coinsurance apply	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS
77055* (76090*) Mammography, bilateral Deductible and coinsurance apply	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS
G0204 Diagnostic Mammography, direct digital image, bilateral, all views Deductible and coinsurance apply	N/A	Lower of: 1. Charge, or 2. 150% TC of MPFS for code 76091	Lower of charge or MPFS
G0206 Diagnostic Mammography, direct digital image, unilateral, all views Deductible and coinsurance apply	N/A	Lower of charge or MPFS	Lower of charge or MPFS

Diagnostic Mammography (Revenue Code 401)	Year 2000	2001 (April 1- March 31, 2002)	April 1, 2002 and later
G0205 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091 or 3. 20.3\$57.28 (annual \$ limit of \$47.08 plus \$10.20TC add on)	N/A
G0207 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	Lower of charge or MPFS	N/A

* For claims with dates of service prior to January 1, 2007, SNFs report CPT codes 76090 and 76091. For claims with dates of service January 1, 2007 and later, SNFs report CPT codes 77055 and 77056 respectively.

Payment for Screening and Diagnostic Computer-Aided Detection (CAD)

Computer-aided Detection (CAD)	Year 2000	2001 (April 1-Dec 31)	Year 2002 and later
76085** CAD with screening mammography (may bill with 77057* (76092*)) No Deductible Coinsurance Applies	N/A	N/A	Lower of: 1. Charge or, 2. TC of MPFS for code 76085
G0236 CAD with diagnostic mammography Deductible and coinsurance apply	N/A	N/A	SNFs cannot be paid for this service

TC = technical component

MPFS= Medicare Physician Fee Schedule

* 76085 is a deleted code after December 31, 2003. Use code 76083* instead of 76085 for claims with dates of service through December 31, 2006, and code 77052 for claims with dates of service January 1, 2007 and later.

* For claims with dates of service prior to January 1, 2007, SNFs report CPT codes 76082, 76083, 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, SNFs report CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.

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

(Rev. 1519, Issued: 05-30-08, Effective: 05-23-08, Implementation: 06-30-08)

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 77057* (76092*).

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 77055* (76090*), 77056* (76091*), G0204 and G0206.

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 prior to January 1, 2007, providers report CPT codes 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055, 77056, and 77057 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. 1, 10-01-03)

20.4.1.1 - RHC/FQHC Claims With Dates of Service Prior to January 1, 2002

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Provider-Based RHC and FQHC

For claims with dates of service prior to January 1, 2002, provider-based RHCs and FQHCs bill the A/B MAC (A) for the technical component and their A/B MACs (B) for the professional component of the screening and diagnostic mammography. Provider-based RHCs and FQHCs use the base provider number and bill type (13X, 22X, 23X or 85X as appropriate) when billing the A/B MAC (A) for this service. Payment is based on the payment method for the base provider - the limitation.

B. Independent RHCs and Freestanding FQHCs

Independent RHCs and freestanding FQHCs bill their A/B MACs (B) for both the technical and professional components. Payment is made based on the limitation.

20.4.1.2 - RHC/FQHC Claims With Dates of Service on or After January 1, 2002

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

A. Provider-Based RHC & FQHC - Technical Component

The technical component of a screening or diagnostic mammography for provider-based RHCs/FQHCs is typically furnished by the base provider. 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 for a screening mammography is 0403, and the appropriate HCPCS codes are 77057*, (76092)*, G0202, 76085, 77052*, and (76083)*. Payment is based on the payment method for the base provider.

The appropriate revenue code for a diagnostic mammography is 0401, and the appropriate HCPCS codes are 77055* (76090*), 77056* (76091*), G0204, G0206, 77051*, (76082)*, and G0236**.

****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 prior to January 1, 2007, report CPT codes **76082**, **76090**, **76091**, and **76092**. For claims with dates of service January 1, 2007 and later, report CPT codes **77051**, **77055**, **77056**, and **77057** respectively.

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) on Form CMS-1500. Payment is based on the MPFS.

C. Provider-Based RHC & FQHC, Independent RHCs and Freestanding FQHCs - Professional Component

For claims with dates of service on or after January 1, 2002 but before April 1, 2005, the professional component of a screening mammography 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 **0403** and HCPCS code **76085*** or **76092**. Payment is made under the all-inclusive rate. Specific revenue coding and HCPCS coding is required for this service in order for CWF to perform age and frequency editing.

***76085** is a deleted code after December 31, 2003. Use **76083** for claims with dates of service on or after January 1, 2004 but before April 1, 2005.

For claims with dates of service on or after January 1, 2002 but before April 1, 2005, RHCs and FQHCs bill the A/B MAC (A) under bill type **71X** or **73X** for the professional component of a diagnostic mammography along with revenue code **0401** and HCPCS codes **76090** or **76091**.

Payment should not be made for a screening or diagnostic mammography unless the claim contains a related visit code. A/B MACs (A) should assure payment is not made for revenue code **0403** (screening mammography) or **0401**(diagnostic mammography). The claim must also contain a visit revenue code **0520** or **0521**. Payment is made for the professional component 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 **0403**.

For claims with dates of service on or after April 1, 2005, the professional component of a screening mammography 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. Payment is made for the professional component under the all-inclusive rate. Additional revenue and HCPCS coding is no longer required for this service when RHCs/FQHCs are billing for the professional component. Use revenue code **0520** or **0521** as appropriate.

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 professional component of a diagnostic mammography. Use revenue code 0520 or 0521 as appropriate. No HCPCS coding is required for the diagnostic mammography.

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

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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 77057* (76092*);
- 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 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.

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

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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.

When a screening CAD (76085**) is billed in conjunction with a screening mammography (77057* (76092*)) and the screening mammography (77057* (76092*) or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

**76085 is a deleted code after December 31, 2003. Use 76083* for claims with dates of service January 1, 2004 through December 31, 2006, and code 77052 for claims with dates of service January 1, 2007 and later.

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.

* For claims with dates of service prior to January 1, 2007, providers report CPT codes 76083 and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77052 and 77057 respectively.

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. 60, 01-09-04)

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 or CAD-diagnostic tests. When a screening CAD is billed in conjunction with a screening mammogram and the screening mammogram fails the age or frequency edits then both services will be rejected.

20.5.1.1 - A/B MACs (B) and CWF Edits

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

The CWF will not edit for POS for screening mammography. Disable 76X1 edit.

Add-on CAD Code 76083 must be billed in conjunction with screening mammography code 76092 or G0202 for claims with dates of service on or after January 1, 2004 through December 31, 2006. For claims with dates of service January 1, 2007 and later, add on CAD code 77052 must be billed in conjunction with screening mammography code 77057 or G0202. Use Type of Service “1”.

Add-on CAD Code 76082 must be billed in conjunction with diagnostic mammography code 76090, 76091, G0204, or G0206 for claims with dates of service on or after January 1, 2004 through December 31, 2006. For claims with dates of service January 1, 2007

and later, add- on CAD code 77051 must be billed in conjunction with diagnostic mammography codes 77055, 77056, G0204 and G0206. Use Type of Service “4”.

Frequency edits apply to screening mammography with or without the CAD code. Screening and diagnostic mammographies (film and digital) are subject to the FDA certification. However, CAD equipment does not require FDA Certification.

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. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

A. Claims With Dates of Service October 1, 1998 Through December 31, 2001

A radiologist who interprets a screening mammography is allowed to order and interpret additional films based on the results of the screening mammogram while the beneficiary is still at the facility for the screening exam. Where a radiologist interpretation results in additional films, the mammography is no longer considered a screening exam for application of age and frequency standards or for payment purposes. This can be done without an additional order from the treating physician. When this occurs, the claim will be billed and paid as a diagnostic mammography instead of a screening mammography. However, since the original intent for the exam was for screening, for statistical purposes, the claim is considered a screening.

The claim should be prepared for A/B MAC (A) processing reflecting the diagnostic revenue code (0401) along with HCPCS code 76090, 76091, G0204, G0206 or G0236 as appropriate and modifier “-GH” “Diagnostic mammogram converted from screening mammogram on same day.” Statistics will be collected based on the presence of modifier “-GH.” A separate claim is not required. Regular billing instructions remain in place for mammograms that do not fit this situation.

A/B MACs (B) should receive a claim for a screening mammogram with CPT code 76092 (screening mammography, bilateral) (Type of Service = 1) **but**, if the screening

mammogram turns into a diagnostic mammogram, the claim is billed with CPT code 76090 (unilateral) or 76091 (bilateral), (TOS= 4), with the “-GH” modifier. A/B MACs (B) pay the claim as a diagnostic mammography instead of a screening mammography.

NOTE: However, the ordering of a diagnostic test by a radiologist following a screening test that shows a potential problem need not be on the same date of service.

In this case, where additional diagnostic tests are performed for the same beneficiary, same visit on the same day, the UPIN of the treating physician is needed on the A/B MACs (B) claim. The radiologist must refer back to the treating physician for his/her UPIN and also report to the treating physician the condition of the patient. A/B MACs (B) need to educate radiologists and treating physicians that the treating physician’s UPIN is required whenever a physician refers or orders a diagnostic lab or radiology service. If no UPIN is present for the diagnostic mammography code, the A/B MACs (B) will reject the claim.

B. Claims With Dates of Service On or After January 1, 2002, (or On or After April 1, 2002 for Hospitals Subject to OPSS)

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 77055* (76090*), 77056* (76091*), G0204, G0206 or G0236 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, 2007, providers report CPT codes 76090 and 76091. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055 and 77056 respectively.

20.7 - Mammograms Performed With New Technologies

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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.

Mammography related CAD equipment does not require FDA certification.

Mammography utilizes a direct x-ray of the breast. By contrast, the CAD process uses laser beam to scan the mammography film from a film (analog) mammography, converts it into digital data for the computer, and analyzes the video display for areas suspicious for cancer. The CAD process used with digital mammography analyzes the data from the mammography on a video display for suspicious areas. The patient is not required to be present for the CAD process.

Only one screening mammogram, either 77057* (76092*) or G0202, may be billed in a calendar year. Therefore, providers/suppliers must not submit claims reflecting both a film screening mammography (77057* (76092*)) and a digital screening mammography G0202. Also, they must not submit claims reflecting HCPCS codes 77055* (76090*) or 77056* (76091*) (diagnostic mammography-film) and G0204 or G0206 (diagnostic mammography-digital). MACs deny the claim when both a film and digital screening or diagnostic mammography is reported. However, a screening and diagnostic mammography can be billed together.

* For claims with dates of service prior to January 1, 2007, providers report CPT codes 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055, 77056, and 77057 respectively.

A. Payment Requirements for A/B MAC (A) Claims With Dates of Service On or After April 1, 2001 Through December 31, 2001 (Through March 31, 2002 for Hospitals Subject to OPPS).

Providers bill the A/B MAC (A) for the technical component of screening and diagnostic mammographies that utilize advanced technologies with one of six new HCPCS codes, G0202 - G0207. See payment methodology below for each of the codes during the

period April 1, 2001 through December 31, 2001 (or March 31, 2002 for hospitals subject to OPPS). Payments for codes G0202 through G0205 are based, in part, on the MPFS payment amounts. The amounts that are based on the MPFS that both A/B MACs (A) and (B) use in calculating the payments for these codes were furnished in a BIPA mammography benefit pricing file for implementation on April 1, 2001.

HCPCS Definition

G0202 Screening mammography producing direct digital image, bilateral, all views

Payment Method:

Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific technical component payment amount under the physician fee schedule for CPT code 76091, the code for bilateral diagnostic mammogram, during 2001.) Part B deductible does not apply. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

HCPCS Definition

G0203 Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views

Payment Method:

Payment will be equal to the lesser of the actual charge for the procedure, the amount that is provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or \$57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the \$15.00 add-on for 2001 which is provided under the new legislation). Part B deductible does not apply. Coinsurance is 20 percent of the charge.

HCPCS Definition

G0204 Diagnostic mammography, direct digital image, bilateral, all views

Payment Method:

Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific amount paid under the physician fee schedule for the technical component (TC) of CPT code 76091, the code for a bilateral diagnostic mammogram.) Deductible is applicable. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

NOTE: Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPPS.

HCPCS Definition

G0205 Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views.

Payment Method:

Payment will be equal to the lesser of the actual charge for the procedure, the amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or \$57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the \$15.00 add-on for 2001 which is provided under the new legislation). Deductible applies. Coinsurance is 20 percent of the charge.

HCPCS Definition

G0206 Diagnostic mammography, direct digital image, unilateral, all views.

Payment Method:

Payment will be made based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (e.g., hospital, rural health clinic, etc.) for CPT code 76090, the code for a mammogram, and one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount under the outpatient prospective payment system (OPPS) for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

NOTE: Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPPS.

HCPCS Definition

G0207 Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views.

Payment Method:

Payment will be based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (e.g., hospital, rural health clinic, etc.) for CPT code 76090, the code for mammogram, and one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount payable under the OPPS for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

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

Codes G0203, G0205 and G0207 are not billable codes 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
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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. Coinsurance is 20 percent of the lower amount; the Program pays 80 percent.
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Deductible does not apply.

G0204	Payment will be made under OPFS 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.
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Deductible applies.

NOTE: Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPFS.

G0206	Payment will be made under OPFS 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.
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Deductible applies.

NOTE: Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPFS.

Providers bill for the technical portion of screening and diagnostic mammograms on Form CMS-1450 under bill type 13X, 22X, 23X, or 85X. The professional component is billed to the A/B MACs (B) on Form CMS-1500 (or electronic equivalent).

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

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
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G0202	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file.
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Part B deductible does not apply, however, coinsurance applies.

G0204	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file.
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Deductible and coinsurance apply.

G0206	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file.
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Deductible and coinsurance apply.

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. 298, Issued: 09-10-04, Effective/Implementation: 09-25-04)

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 this service (film mammography) or if the claim is denied because the provider is not certified to perform this service (digital 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. 3536, Issued: 06-08-16, Effective: 07-01-16, Implementation: 07- 05-16 - for MCS system changes; October 3, 2016- for FISS)

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

For A/B MACs (A) only:

If the claim is denied because the provider that performed the screening is not certified to perform the type of mammography billed (film 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 A/B MACs (B) only:

For claims submitted by a facility not certified to perform film mammography, 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: 171
RARC: N110
Group Code: CO

For claims submitted by a facility not certified to perform digital mammograms, 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: 171
RARC: N92
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)(l) 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 OPFS and January 1, 2016 MPFS. HCPCS G0476 will be effective retroactive to July 9, 2015 in the IOCE & OPFS.

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 OPFS. 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. 3522, Issued: 05-13-16, Effective: 06-14-16, Implementation: 06-14-16)

Below is the current diagnoses that should be used when billing for screening Pap smear services. Effective July 1, 2005, ICD-9 V72.31 is being added to the CWF edit as an additional low-risk diagnosis. The following chart lists the diagnosis codes that CWF must recognize for low-risk or high-risk patients for screening Pap smear services.

Low Risk Diagnosis Codes	Definitions
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites NOTE: providers use this diagnosis for women without a cervix.
V72.31	Routine gynecological examination NOTE: This diagnosis should only be used when the provider performs a full gynecological examination.
High Risk Diagnosis Code	
V15.89	Other specified personal history presenting hazards to health

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 V76.2, V76.47, V76.49 and (effective July 1, 2005, V72.31) or the high-risk diagnosis of V15.89 (for high risk patients). One of the above diagnoses must be listed in item 21 of 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 of V15.89 appears in Item 21 and V15.89 is the appropriate diagnosis code 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 diagnosis codes:

ICD-9 V76.2, special screening for malignant neoplasms, cervix, or,
ICD-9 V76.47, special screening for malignant neoplasms, vagina, or,
ICD-9 V76.49, special screening for malignant neoplasms, other sites (used for women without a cervix), or,
ICD-9 V72.31, routine gynecological exams

ICD-10 Z12.4, encounter for screening for malignant neoplasm of the cervix
ICD-10 Z12.72, encounter for screening for malignant neoplasm of the vagina
ICD-10 Z12.79, encounter for screening for malignant neoplasm of other genitourinary organs, or,
ICD-10 Z12.89, encounter for screening for malignant neoplasm of other sites
ICD-10 Z01.411, encounter for gynecological exam (general)(routine) with abnormal findings, or,
ICD-10 Z01.419, encounter for gynecological exam (general)(routine) without abnormal findings

High-risk diagnosis codes

ICD-9 V15.89, other specified personal history hazardous to health
ICD-9 V87.39, contact with and (suspected) exposure to other potentially hazardous substances
ICD-9 V69.2, high-risk sexual behavior

ICD-10 Z77.9, other contact with and (suspected) exposures hazardous to health, or,
ICD-10 Z91.89, other specified personal risk factors, not elsewhere classified, or,

ICD-10 Z92.89, personal history of other medical treatment, or,
ICD-10 Z77.29, contact with and (suspected) exposure to other hazardous substances
ICD-10 Z72.51, high-risk heterosexual behavior, or,
ICD-10 Z72.52, high-risk homosexual behavior, or,
ICD-10 Z72.53, high-risk bisexual behavior.

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-9: V73.81, special screening exam, HPV (as primary), and V72.31, routine gynecological exam (as secondary)

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. 3615, Issued: 09-23-16, Effective: 12-27-16, Implementation: 12-27-16)

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-9 or ICD-10 diagnosis codes listed below:

ICD-9: V73.81 and V72.31

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. 3615, Issued: 09-23-16, Effective: 12-27-16, Implementation: 12-27-16)

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-9 or ICD-10 diagnosis codes listed below:

ICD-9: V73.81 and V72.31

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. 1, 10-01-03)

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. The provider uses one of the following ICD-9-CM codes V76.2, V76.47, or V76.49. 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-9-CM code V15.89, other specified personal history presenting hazards to health.) 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-9-CM code V15.89, other specified personal history presenting hazards to health 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. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

Below are the current diagnoses that should be used when billing for screening pelvic examination services. Effective, July 1, 2005, ICD-9-CM diagnosis code V72.31 was added to the CWF edit as an additional low risk diagnosis. The following chart lists the diagnosis codes that CWF must recognize for low risk or high risk patients for screening pelvic examination services.

Low Risk Diagnosis Codes

ICD-9- CM codes	Description	ICD-10- CM codes	Description
V72.31	Routine gynecological examination— NOTE: This diagnosis should only be used when the provider performs a full gynecological examination.	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
V72.31	Routine gynecological examination- NOTE: This diagnosis should only be used when the provider performs a full gynecological examination	Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
V76.2	Screening for malignant neoplasms of the cervix	Z12.4	Encounter for screening for malignant neoplasm of cervix
V76.47	Special screening for malignant neoplasms, vagina	Z12.72	Encounter for screening for malignant neoplasm of vagina
V76.49	Special screening for malignant neoplasms, other sites NOTE: Providers use this diagnosis for women without a cervix.	Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
V76.49	Special screening for malignant neoplasms, other sites- NOTE: Providers use this diagnosis for women without a cervix.	Z12.89	Encounter for screening for malignant neoplasm of other sites

High Risk Diagnosis Codes

ICD-9-CM codes	Description	ICD-10-CM codes	Description
V15.89	Other specified personal history presenting hazards to health	Z77.22	Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)
V15.89	Other specified personal history presenting hazards to health	Z77.9	Other contact with and (suspected) exposures hazardous to health
V15.89	Other specified personal history presenting hazards to health	Z91.89	Other specified personal risk factors, not elsewhere classified
V15.89	Other specified personal history presenting hazards to health	Z72.89	Personal history of other medical treatment
V69.2	High risk sexual behavior	Z72.51	High risk heterosexual behavior
V69.2	High risk sexual behavior	Z72.52	High risk homosexual behavior
V69.2	High risk sexual behavior	Z72.53	High risk bisexual behavior

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. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

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 §1861(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. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

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

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. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

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

50.5 - Diagnosis Coding

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

Prostate cancer screening digital rectal examinations and screening Prostate Specific Antigen (PSA) blood tests must be billed using either screening (“V”) code V76.44 (Special Screening for Malignant Neoplasms, Prostate if ICD-9-CM is applicable) or 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. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

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 M140 “Service is not covered until after the patient’s 50th birthday, i.e., no coverage prior to the day after the 50th birthday.”

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-9-CM diagnosis code V76.44, or ICD-10-CM diagnosis code Z12.5 on the claim, use the ASC X12 835 claim adjustment reason code 47, “This (these) diagnosis(es) is (are) not covered, missing, or invalid.”

60 - Colorectal Cancer Screening

(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.)

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:

- Fecal-occult blood test, immunoassay, 1-3 simultaneous determinations

Effective for claims with dates of service on or after October 9, 2014, payment may be made for colorectal cancer screening using the Cologuard™ multitarget stool DNA (sDNA) test:

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

60.1 - Payment

(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.)

Payment is under the Medicare Physician Fee Schedule (MPFS) except as follows:

- FOBTs [CPT 82270* (HCPCS G0107*) and HCPCS G0328] are paid under the clinical laboratory fee schedule (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, the Cologuard™ multitarget 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.

- 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, and G0464 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) 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. 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.)

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). When a screening colonoscopy becomes a diagnostic colonoscopy anesthesia code 00810 should be submitted with only the -PT modifier and only the deductible will be 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 January 1, 2015, coinsurance and deductible are waived for anesthesia services CPT 00810, Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum, when performed for screening colonoscopy services and when billed with Modifier 33.

Effective for claims with dates of service on and after October 9, 2014, deductible and coinsurance do not apply to the Cologuard™ multitarget sDNA screening test (HCPCS G0464).

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.

60.2 - HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable)

(Rev. 3368, Issued: 10-09-15, Effective: 01-01-16, Implementation: 01-01-16)

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 (noncovered).

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)

***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, nurse practitioner, or clinical nurse specialist (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).

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 Screening; 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 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 Medicare physician fee schedule 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, Ambulatory Surgical Centers (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 (code 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 (code 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.

CPT 82270* (HCPCS G0107*) - Colorectal Cancer Screening; Fecal-Occult Blood Test, 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, nurse practitioner, or clinical nurse specialist. (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.

HCPCS G0328 - Colorectal Cancer Screening; Immunoassay, Fecal-Occult Blood Test, 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 physician assistant, nurse practitioner, or clinical nurse specialist. (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.)

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.

HCPCS G0121 - Colorectal 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 - Multitarget Stool DNA (sDNA) Colorectal Cancer Screening Test - Cologuard™

Effective for dates of service on or after October 9, 2014, colorectal cancer screening using the Cologuard™ multitarget sDNA test (G0464) 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 fecal occult blood test 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 cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

See Pub. 100-03, Medicare National Coverage Determinations Manual, chapter 1, section 210.3, for complete coverage requirements.

Effective for claims with dates of service on or after October 9, 2014, providers shall report the following diagnosis codes when submitting claims for the Cologuard™ multitarget sDNA test:

ICD-9: V76.41 and V76.51, or,
ICD-10: Z12.11 and Z12.12

HCPCS G0122 - Colorectal Cancer Screening; Barium Enema

The code is not covered by Medicare.

60.2.1 - Common Working Files (CWF) Edits

(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.)

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, and 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.

60.2.2 - Ambulatory Surgical Center (ASC) Facility Fee **(Rev. 1160, Issued: 01-19-07, Effective: 01-01-07, Implementation: 07-02-07)**

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 1833 of the Act. CPT code 45378 is currently assigned to ASC payment group 2. Code G0105, colorectal cancer screening; 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 screening; 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 percent coinsurance payment will apply for the colorectal cancer screening services (G0105 and G0121).

60.3 - Determining High Risk for Developing Colorectal Cancer **(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)**

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-9-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.

Personal History	
V10.05	Personal history of malignant neoplasm of large intestine
V10.06	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
Chronic Digestive Disease Condition:	
555.0	Regional enteritis of small intestine
555.1	Regional enteritis of large intestine
555.2	Regional enteritis of small intestine with large intestine
555.9	Regional enteritis of unspecified site
556.0	Ulcerative (chronic) enterocolitis
556.1	Ulcerative (chronic) ileocolitis
556.2	Ulcerative (chronic) proctitis
556.3	Ulcerative (chronic) proctosigmoiditis
556.8	Other ulcerative colitis
556.9	Ulcerative colitis, unspecified (non-specific PDX on the MCE)
Inflammatory Bowel:	
558.2	Toxic gastroenteritis and colitis
558.9	Other and unspecified non-infectious gastroenteritis and colitis
Other ICD-9-CM	
211.3	Benign neoplasm of colon
V76.51	Special screening for malignant neoplasms of colon
V76.41	Screening for malignant neoplasms of rectum
V84.09	Genetic susceptibility to other malignant neoplasm
V16.0	Family history of malignant neoplasm of gastrointestinal tract
V18.51	Family history of colonic polyps

C. 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. Use ICD-10-CM codes once ICD-10 is implemented.

ICD-10-CM	Description
D12.6	Benign neoplasm of colon, unspecified
K50.00	Crohn's disease of small intestine without complications
K50.011	Crohn's disease of small intestine with rectal bleeding

ICD-10-CM	Description
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
K51.20	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

ICD-10-CM	Description
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 complication
K51.80	Other ulcerative colitis without complications
K51.80	Other ulcerative colitis without 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 noninfective gastroenteritis and colitis
K52.9	Noninfective gastroenteritis and colitis, unspecified
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
Z83.71	Family history of colonic polyps
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

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. 1, 10-01-03)

B3-4180.5, A3-3660.17, HO-456.C

The following noncovered 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 screening; 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 noncovered 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 screening; 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 noncovered 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. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

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	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.

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 the Common Working File (CWF) as a result of the hospital bundling rules.

60.7 - Medicare Summary Notice (MSN) Messages

(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.)

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:

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

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 patients 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™ multitarget sDNA screening test (HCPCS G0464) 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 - 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).

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, 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™ multitarget sDNA screening test (HCPCS G0464) because the beneficiary is not between the ages of 50 and 85, use:

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).

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 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.

H. If denying claims for Cologuard™ multitarget sDNA screening test (HCPCS G0464) because the claim does not contain all of the ICD-9 or ICD-10 diagnosis codes required, use:

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).

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™ multitarget sDNA screening test (HCPCS G0464) 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. 3436, Issued: 12-30-2015, Effective: 10-09-2014, Implementation: 09-08-2015 for non-shared MAC edits; 01-04- 2016 - For all shared system changes.)

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 50 years of age, use:

- Claim Adjustment Reason Code (CARC) 6 “the procedure code is inconsistent with the patient’s age,” at the line level; and,
- Remittance Advice Remark Code (RARC) M82 “Service is not covered when patient is under age 50.” at the line level.

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 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 noncovered screening procedure such as HCPCS G0122, use:

- CARC 49, “These are noncovered 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™ multitarget sDNA screening test (HCPCS G0464) 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™ multitarget sDNA screening test (HCPCS G0464) when beneficiary is not between the ages 50-85, 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™ multitarget sDNA screening test (HCPCS G0464) when the claim does not contain diagnosis codes V76.41 and V76.51 (ICD-10: Z12.12 and Z12.11 when effective), 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™ multitarget sDNA screening test (HCPCS G0464) 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 físico 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 mellitus 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 Z13.1 in 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

Facility	Type of Bill	Payment
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 OPFS	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
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

Type of Facility	Payment Method	Type of Bill
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 (13th 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. 2199, Issued: 04-22-11, Effective: 12-08-09, Implementation: 07-06-10)

130.1 - Healthcare Common Procedure Coding System (HCPCS) for HIV Screening Tests (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)

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.

Effective for claims with dates of service on or after April 13, 2015, the following HCPCS code may be billed for HIV screening:

- G0475 - HIV antigen/antibody, combination assay, screening

130.2 - Billing Requirements

(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)

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 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

Claims shall contain HCPCS code 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.

Claims shall contain HCPCS code 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. 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)

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 OPFS and January 1, 2016 MPFS. HCPCS code G0475 will be effective retroactive to April 13, 2015 in the IOCE & OPFS.

A/B MACs (B) shall only accept claims submitted with a G0475 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. 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)

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: 009.90 Supervision of high risk pregnancy, unspecified, unspecified trimester

009.91 Supervision of high risk pregnancy, unspecified, first trimester

009.92 Supervision of high risk pregnancy, unspecified, second trimester

009.93 Supervision of high risk pregnancy, unspecified, third trimester

130.6 - Medicare Summary Notice (MSN) and Claim Adjustment Reason Codes (CARCs)

(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)

- 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 artículo o servicio”

Claim Adjustment Reason Code (CARC) 167- This (these) diagnosis(es) is (are) not covered.

Group Code CO - (Contractual Obligation)

- 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 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.”

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 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, not submitted with the appropriate, primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4, regardless of the presence of risk factor, 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). A n 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 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.

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 AWWs. The type of service (TOS) for each of the new codes is 1. AWW 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 AWW 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 AWW 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 AWW (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 AWW 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 AWW, HCPCS G0438, when a first AWW, 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 AWW, HCPCS G0439, because a previous AWW, 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 AWW, 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 AWW, 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. 3428 Issued: 12-22-15, Effective: 01-01-16, Implementation: 01-04-16)

For services furnished on or after January 1, 2016, Advance Care Planning (ACP) is treated as a preventive service when furnished with an AWW. The Medicare coinsurance and Part B deductible are waived for ACP when furnished as an optional element of an AWW.

The codes for the optional ACP services furnished as part of an AWW 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 AWP, practitioners would report CPT code 99497 (and add-on CPT code 99498 when applicable) for the ACP services in addition to either of the AWP codes (G0438 or G0439).

The deductible and coinsurance for ACP will only be waived when billed with modifier 33 on the same day and on the same claim as an AWP (code G0438 or G0439), and must also be furnished by the same provider. Waiver of the deductible and coinsurance for ACP is limited to once per year. Payment for an AWP is limited to once per year. If the AWP billed with ACP is denied for exceeding the once per year limit, the deductible and coinsurance will be applied to the ACP.

Also see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.5.1 for more information.

150 - Counseling to Prevent Tobacco Use

(Rev. 2058, Issued: 09-30-10, Effective: 08-25-10, Implementation: 01-03-11)

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:

1. Who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease;
2. Who are competent and alert at the time that counseling is provided; and,
3. 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.

150.1 - Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Coding

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

The CMS has created two new G 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. These are in addition to the two CPT codes 99406 and 99407 that currently are used for smoking and tobacco-use cessation counseling for symptomatic individuals.

The following HCPCS codes should be reported when billing for counseling to prevent tobacco use effective January 1, 2011:

G0436 - 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

G0437 - Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes

Short descriptor: Tobacco-use counsel >10min

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 G0436 and G0437 shall be submitted with the applicable diagnosis codes:

ICD-9-CM

V15.82, history of tobacco use, or
305.1, non-dependent tobacco use disorder

ICD-10-CM

F17.200, nicotine dependence, unspecified, uncomplicated,
F17.201, nicotine dependence, unspecified, in remission,
F17.210, nicotine dependence, cigarettes, uncomplicated,
F17.211, nicotine dependence, cigarettes, in remission,

F17.220, nicotine dependence, chewing tobacco, uncomplicated,
F17.221, nicotine dependence, chewing tobacco, in remission,
F17.290, nicotine dependence, other tobacco product, uncomplicated,
F17.291, nicotine dependence, other tobacco product, in remission, or
Z87.891, personal history of nicotine dependence, unspecified, uncomplicated.

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 G0436 or G0437.

150.2 - A/B MACs (B) Billing Requirements

(Rev. 2058, Issued: 09-30-10, Effective: 08-25-10, Implementation: 01-03-11)

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.

150.2.1 - A/B MAC (A) and (HHH) Billing Requirements

(Rev. 2058, Issued: 09-30-10, Effective: 08-25-10, Implementation: 01-03-11)

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 OPFS, 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.

Payment for outpatient services is as follows:

Type of Facility	Method of Payment
Rural Health Centers (RHCs) TOB 71X/Federally Qualified Health Centers (FQHCs)TOB 77X	All-inclusive rate (AIR) 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.

150.3 - Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claims Adjustment Reason Codes (CARCs), and Group Codes

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

When denying claims for counseling to prevent tobacco use services submitted without ICD-9-CM diagnosis codes 305.1 or, if ICD-10-CM is applicable, one of the following diagnosis codes:

F17.201 - Nicotine dependence, unspecified, in remission
F17.210 - Nicotine dependence, cigarettes, uncomplicated
F17.211 - Nicotine dependence, cigarettes, in remission

F17.220 - Nicotine dependence, chewing tobacco, uncomplicated
F17.221 - Nicotine dependence, chewing tobacco, in remission
F17.290 - Nicotine dependence, other tobacco product, uncomplicated
F17.291 - Nicotine dependence, other tobacco product, in remission

or without ICD-9-CM code V15.82, or if ICD-10-CM is applicable, Z87.891 or F17.200, A/B MACs (A), (B), or (HHH) shall use the following messages:

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

RARC M64 - "Missing/incomplete/invalid other diagnosis"

CARC 167 This (these) diagnosis(es) is (are) not covered, missing, or are invalid.

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.

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 (G0436, G0437, 99406, 99407), A/B MACs (A), (B), or (HHH) shall use the following messages:

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."

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.

150.4 - Common Working File (CWF)

(Rev. 2058, Issued: 09-30-10, Effective: 08-25-10, Implementation: 01-03-11)

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 (G0436, G0437, 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. 2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

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 codes:

- Chlamydia: 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800 (used for combined chlamydia and gonorrhea testing)
- Gonorrhea: 87590, 87591, 87850, 87800 (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. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

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 not pregnant use the following ICD-9-CM diagnosis codes:

- V74.5 - Screening, bacterial - sexually transmitted; and
- V69.8 - Other problems related to lifestyle as secondary. (This diagnosis code is used to indicate high/increased risk for STIs).

Effective with the implementation of ICD-10, 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 ,
 - Z72.51 - High risk heterosexual behavior,
 - 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-9-CM diagnosis codes:

- V74.5 - Screening, bacterial - sexually transmitted; and
- V69.8 - Other problems related to lifestyle as secondary.

Effective with the implementation of ICD-10, 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 ,
- Z72.51 - High risk heterosexual behavior,
- Z72.52 - High risk homosexual behavior, or
- Z72.53 - High risk bisexual behavior.

c. For claims for screening for chlamydia and gonorrhea in pregnant women at increased risk for STIs use the following ICD-9-CM diagnosis codes, if applicable:

- V74.5 - Screening, bacterial - sexually transmitted; and
- V69.8 - Other problems related to lifestyle, and
- one of,
 - V22.0 - Supervision of normal first pregnancy, or
 - V22.1 - Supervision of other normal pregnancy, or,
 - V23.9 - Supervision of unspecified high-risk pregnancy.

Effective with the implementation of ICD-10, use ICD-10-CM diagnosis code Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; **and** one of:

- Z72.89 - Other problems related to lifestyle ,
- Z72.51 - High risk heterosexual behavior,
- 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
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

Code	Description
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-9-CM diagnosis codes:

- V74.5 - Screening, bacterial - sexually transmitted; and
- V22.0 - Supervision of normal first pregnancy, or,
- V22.1 - Supervision of other normal pregnancy, or,
- V23.9 - Supervision of unspecified high-risk pregnancy.

Effective with the implementation of ICD-10, 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

Code	Description
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-9-CM diagnosis codes:

- V74.5 - Screening, bacterial - sexually transmitted; and
- V69.8 - Other problems related to lifestyle, and,
- V22.0 - Supervision of normal first pregnancy, or
- V22.1 - Supervision of other normal pregnancy, or,
- V23.9 - Supervision of unspecified high-risk pregnancy.

Effective with the implementation of ICD-10, 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

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

Code	Description
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-9-CM diagnosis codes:

- V73.89 - Screening, disease or disorder, viral, specified type NEC; and
- V22.0 - Supervision of normal first pregnancy, or,
- V22.1 - Supervision of other normal pregnancy, or,
- V23.9 - Supervision of unspecified high-risk pregnancy.

Effective with the implementation of ICD-10, 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-9-CM diagnosis codes:

- V73.89 - Screening, disease or disorder, viral, specified type NEC; and
- V 69.8 - Other problems related to lifestyle, and,
- V22.0 - Supervision of normal first pregnancy, or,
- V22.1 - Supervision of other normal pregnancy, or,
- V23.9 - Supervision of unspecified high-risk pregnancy.

Effective with the implementation of ICD-10, 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
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. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

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-9-CM diagnosis code V69.8 or 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-9-CM diagnosis code V74.5 or if ICD-10 is applicable, ICD-10-CM diagnosis code Z11.3); and/or hepatitis B (as indicated by the presence of ICD-9-CM diagnosis code V73.89 or 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. 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 claims, G0444, only when services are provided at the following places of service (POS):

- 11 - Office
- 22 - 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. 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 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.

- 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 as 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.

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: 11-Office; 22-Outpatient Hospital; 49-Independent Clinic; and 71-State or Local Public Health Center.

- 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.”
- 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.

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 ≥ 30 kg/m²) 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 ≥ 30 kg/m²) 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.

<u>ICD-10-CM</u>	<u>Description</u>
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. 3393, Issued: 11-05-15, Effective: 06-02-14, Implementation: 04-04-16)

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-9 diagnosis code V69.8, other problems related to lifestyle/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented), and ICD-9 diagnosis code 304.91, unspecified drug dependence, continuous/ICD-10 diagnosis code F19.20, other psychoactive substance dependence, uncomplicated (once ICD-10 is implemented):

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 políticas 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-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), 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 políticas 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 V69.8 /ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented) or 304.91/ ICD-10 diagnosis code F19.20 (once ICD-10 is implemented)):

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 políticas 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. 3285, Issued: 06-19-15, Effective: 06-02-14, Implementation: For FISS shared system edits, split between October 5, 2015, and January 4, 2016, releases; July 20, 2015, - For non-shared MAC edits; October 5, 2015 - For CWF shared systems)

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 V69.8/ICD-10 diagnosis

code Z72.89 (once ICD-10 is implemented) and/or 304.91/ ICD-10 diagnosis code F19.20 (once ICD-10 is implemented)).

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 (RARC), Group Codes, and Medicare Summary Notice (MSN) Messages

(Rev. 3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

Contractors shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARC), group codes, or Medicare summary notice (MSN) messages when denying payment for LDCT lung cancer screening services, HCPCS codes G0296 and G0297:

- 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.

- 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, 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 G0297 because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered:

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 G0297 because the claim line was not billed with ICD-9 code V15.82 (ICD-10 Z87.891, personal history of tobacco use/personal history of nicotine dependence):

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. 3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

The common working file (CWF) shall apply the following limitations to lung cancer screening with LDCT:

Allow one HCPCS code G0297 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 G0297 claims lines for beneficiaries that are not between the ages of 55 and 77.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Implementation Date	CR#
<u>R3711CP</u>	02/03/2017	Implementation of New Influenza Virus Vaccine Code	07/03/2017	9876
<u>R3669CP</u>	12/02/2016	HCPCS Code Update for Preventive Services	01/03/2016	9888
<u>R3621CP</u>	10/07/2016	Billing of Vaccine Services on Hospice Claims	10/03/2016	9052
<u>R3617CP</u>	09/30/2016	Implementation of New Influenza Virus Vaccine Code	01/03/2016	9793
<u>R3615CP</u>	09/23/2016	Update to Hepatitis B Deductible and Coinsurance and Screening Pap Smears Claims Processing Information	12/27/2016	9778
<u>R3540CP</u>	06/10/2016	Billing of Vaccine Services on Hospice Claims – Rescinded and replaced by Transmittal 3621	10/03/2016	9052
<u>R3536CP</u>	06/08/2016	CMS Mammography Quality Standards Act (MQSA) File Reformatting-Implementation	10/03/2016	9492
<u>R3522CP</u>	05/13/2016	Update to Internet-Only-Manual Publication 100-04, Chapter 18, Section 30.6	06/14/2016	9606
<u>R3503CP</u>	04/28/2016	Billing of Vaccine Services on Hospice Claims – Rescinded and replaced by Transmittal 3540	10/03/2016	9052
<u>R3463CP</u>	02/12/2016	CMS Mammography Quality Standards Act (MQSA) File Reformatting-Implementation – Rescinded and replaced by Transmittal 3536	10/03/2016	9492
<u>R3461CP</u>	02/05/2016	Screening for the Human Immunodeficiency Virus (HIV) Infection	03/07/2016	9403

Rev #	Issue Date	Subject	Implementation Date	CR#
<u>R3460CP</u>	02/05/2016	Screening for Cervical Cancer With Human Papillomavirus (HPV) Testing—National Coverage Determination (NCD)	03/07/2016	9434
<u>R3436CP</u>	12/30/2015	National Coverage Determination (NCD) for Screening for Colorectal Cancer Using Cologuard™ - A Multitarget Stool DNA Test	09/08/2015	9115
<u>R3429CP</u>	12/22/2015	New Influenza Virus Vaccine Code – Rescinded and replaced by Transmittal 3429	12/11/2015	9357
<u>R3428CP</u>	12/22/2015	Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)	01/04/2016	9271
<u>R3403CP</u>	11/09/2015	New Influenza Virus Vaccine Code – Rescinded and replaced by Transmittal 3429	12/11/2015	9357
<u>R3393CP</u>	11/05/2015	Reporting of Type of Bill (TOB) 014x for Billing Screening of Hepatitis C Virus (HCV) in Adults	04/04/2016	9360
<u>R3374CP</u>	10/15/2015	Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)	01/04/2015	9246
<u>R3368CP</u>	10/09/2015	New Values for Incomplete Colonoscopies Billed with Modifier 53	01/01/2016	9317
<u>R3338CP</u>	08/21/2015	Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT) – Rescinded and replaced by Transmittal 3374	01/04/2015	9246
<u>R3329CP</u>	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

Rev #	Issue Date	Subject	Implementation Date	CR#
<u>R3319CP</u>	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
<u>R3318CP</u>	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
<u>R3315CP</u>	08/06/2015	New and Revised Place of Service Codes (POS) for Outpatient Hospital	01/04/2016	9231
<u>R3301CP</u>	08/06/2015	Claims Processing Instructions for Diagnostic Digital Breast Tomosynthesis	01/04/2016	9191
<u>R3285CP</u>	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
<u>R3232CP</u>	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
<u>R3215CP</u>	03/11/2015	Screening for Hepatitis C Virus (HCV) in Adults	01/05/2015	8871
<u>R3160CP</u>	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

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<u>R3159CP</u>	12/31/2015	Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations	02/02/2015	9051
<u>R3146CP</u>	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
<u>R3127CP</u>	11/19/2014	Screening for Hepatitis C Virus (HCV) in Adults – Rescinded and replaced by Transmittal 3215	01/05/2015	8871
<u>R3096CP</u>	10/17/2014	Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) and Screening Fecal-Occult Blood Tests (FOBT)	11/18/2014	8881
<u>R3094CP</u>	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
<u>R3063CP</u>	09/05/2014	Screening for Hepatitis C Virus (HCV) in Adults – Rescinded and replaced by Transmittal 3127	01/05/2015	8871
<u>R3042CP</u>	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	01/05/2015	8874
<u>R2824CP</u>	11/22/2013	New Influenza Virus Vaccine Code	04/07/2014	8473

Rev #	Issue Date	Subject	Implementation Date	CR#
<u>R2693CP</u>	05/02/2013	New Influenza Virus and Hepatitis B Virus Vaccine Codes	10/07/2013	8249
<u>R2575CP</u>	10/26/2012	Editing Updating for Annual Wellness Visit (AWV)	04/01/2013	8107
<u>R2476CP</u>	05/23/2012	Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs (ICD-10)	02/27/2012	7610
<u>R2446CP</u>	04/26/2012	New Influenza Virus Vaccine Code	10/01/2012	7794
<u>R2438CP</u>	04/04/2012	Revised Editing for Hepatitis B Administration Code G0010	07/02/2012	7692
<u>R2433CP</u>	03/26/2012	Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	12/27/2011	7633
<u>R2432CP</u>	03/23/2012	Intensive Behavioral Therapy for Cardiovascular Disease	12/27/2011	7636
<u>R2431CP</u>	03/23/2012	Screening for Depression in Adults	12/27/2011	7637
<u>R2421CP</u>	03/07/2012	Intensive Behavioral Therapy for Obesity	03/06/2012	7641
<u>R2409CP</u>	02/03/2012	Intensive Behavioral Therapy for Obesity – Rescinded and replaced by Transmittal 2421	03/06/2012	7641
<u>R2402CP</u>	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
<u>R2390CP</u>	01/25/2012	Revised Editing for Hepatitis B Administration Code G0010 –	07/02/2012	7692

Rev #	Issue Date	Subject	Implementation Date	CR#
		Rescinded and replaced by Transmittal 2438		
<u>R2359CP</u>	11/23/2011	Screening for Depression in Adults – Rescinded and replaced by Transmittal 2431	12/27/2011	7637
<u>R2358CP</u>	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
<u>R2357CP</u>	11/23/2011	Intensive Behavioral Therapy for Cardiovascular Disease – Rescinded and replaced by Transmittal 2432	12/27/2011	7636
<u>R2337CP</u>	10/28/2011	New Influenza Virus Vaccine Code	04/02/2012	7580
<u>R2267CP</u>	08/01/2011	Common Working File (CWF) Editing for Influenza Virus Vaccine and Pneumococcal Vaccine Codes	01/03/2012	7461
<u>R2253CP</u>	07/08/2011	Influenza Virus Vaccine	08/08/2011	7453
<u>R2233CP</u>	05/27/2011	Medicare Preventive and Screening Services	06/28/2011	7423
<u>R2199CP</u>	04/22/2011	Screening for the Human Immunodeficiency Virus (HIV) Infection	07/06/2010	6786
<u>R2163CP</u>	02/23/2011	Screening for the Human Immunodeficiency Virus (HIV) Infection – Rescinded and replaced by Transmittal 2199	07/06/2010	6786
<u>R2159CP</u>	02/15/2011	Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)	04/04/2011	7079
<u>R2154CP</u>	02/11/2011	Payment Update and Common Working File (CWF) Editing for Influenza Virus	07/05/2011	7128

Rev #	Issue Date	Subject	Implementation Date	CR#
		Vaccine and Pneumococcal Vaccine Codes		
<u>R2109CP</u>	12/03/2010	Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS) – Rescinded and replaced by Transmittal 2159	04/04/2011	7079
<u>R2058CP</u>	09/30/2010	Counseling to Prevent Tobacco Use	01/03/2011	7133
<u>R1953CP</u>	04/28/2010	Use of 12X Type of Bill (TOB) for Billing Colorectal Screening Services	10/04/2010	6760
<u>R1935CP</u>	03/23/2010	Screening for the Human Immunodeficiency Virus (HIV) Infection – Rescinded and replaced by Transmittal 2163	07/06/2010	6786
<u>R1931CP</u>	03/12/2010	Revision of the Internet Only Manual (IOM) to Remove References to “Purchased Diagnostic Test” and Replace With Language Consistent With the Anti-Markup Rule	06/14/2010	6627
<u>R1918CP</u>	02/19/2010	Screening for the Human Immunodeficiency Virus (HIV) Infection - Rescinded and replaced by Transmittal 1935	07/06/2010	6786
<u>R1846CP</u>	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
<u>R1719CP</u>	04/24/2009	Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) Updates	10/05/2009	6445
<u>R1624CP</u>	10/31/2008	Reporting of National Provider Identifiers (NPI) on Claims for Out-of-Jurisdiction Purchased Mammography	12/01/2008	6237

Rev #	Issue Date	Subject	Implementation Date	CR#
		Preventive Screening and Diagnostic Services		
<u>R1617CP</u>	10/24/2008	Common Working File (CWF) Editing for Influenza Virus Vaccine and Pneumococcal Vaccine Codes	04/06/2009	6224
<u>R1615CP</u>	10/17/2008	Update to the Initial Preventive Physical Examination (IPPE) Benefit	01/05/2009	6223
<u>R1586CP</u>	09/05/2008	Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines	10/06/2008	6079
<u>R1541CP</u>	06/20/2008	Screening Pelvic Examinations	09/23/2008	6085
<u>R1519CP</u>	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
<u>R1472CP</u>	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
<u>R1459CP</u>	02/22/2008	Comprehensive Outpatient Rehabilitation Facility (CORF) Billing Requirement Updates for Fiscal Year (FY) 2008	07/07/2008	5898
<u>R1461CP</u>	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
<u>R1421CP</u>	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
<u>R1387CP</u>	12/07/2007	Mammography: Change Certification-Based Action From Return to Provider	04/07/2008	5577

Rev #	Issue Date	Subject	Implementation Date	CR#
		(RTP)/Return as Unprocessable to Reject/Denial		
<u>R1325CP</u>	08/29/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes	01/07/2008	5680
<u>R1308CP</u>	07/20/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes – Replaced by Transmittal 1325	01/07/2008	5680
<u>R1278CP</u>	06/29/2007	Update to Pub.100-04, Chapter 18, Section 10 for Part B Influenza Billing	07/30/2007	5511
<u>R1255CP</u>	05/25/2007	Guidelines for Payment of Diabetes Self-Management Training DSMT)	07/02/2007	5433
<u>R1217CP</u>	03/30/2007	Update to Internet Only Manual (IOM) Publication 100-04, Chapter 18, Section 60.1	07/02/2007	5541
<u>R1160CP</u>	01/19/2007	Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change	07/02/2007	5387
<u>R1158CP</u>	01/19/2007	Guidelines for Diabetes Self-Management Training (DSMT) – Replaced by Transmittal 1255	07/02/2007	5433
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<u>R633CP</u>	08/03/2005	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
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<u>R544CP</u>	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
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<u>R408CP</u>	12/17/2004	Cardiovascular Disease Screening	01/03/2005	3411
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<u>R337CP</u>	10/29/2004	Change in Hospital Type of Bill for Billing Diagnostic and Screening Mammographies	04/04/2005	3469
<u>R298CP</u>	09/10/2004	For carriers, reason codes and remark codes have been added to the IOM for more interpretations	09/25/2004	2617
<u>R295CP</u>	09/03/2004	For carriers, reason codes and remark codes have been added to the IOM for more interpretations	09/25/2004	2617
<u>R260CP</u>	07/30/2004	Billing for Cryosurgery of the Prostate	01/03/2005	3168

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<u>R214CP</u>	06/25/2004	For carriers, reason codes and remark codes have been added to the IOM for more interpretations	09/25/2004	2617
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<u>R060CP</u>	01/09/2004	New CAD codes for film and digital mammography services	N/A	2632
<u>R052CP</u>	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
<u>R040CP</u>	12/08/2003	New ICD-9 Code V04 81 for billing the influenza virus vaccine benefit	N/A	2763
<u>R033CP</u>	11/28/2003	MQSA File Record Layout for the FDA Certified Digital Mammography Center	N/A	1729
<u>R001CP</u>	10/01/2003	Initial Publication of Manual	NA	NA

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