CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1875	**Date: July 27, 2017**
	Change Request 10184

SUBJECT: ICD-10 Coding Revisions to National Coverage Determinations (NCDs)

I. SUMMARY OF CHANGES: This Change Request (CR) constitutes a maintenance update of International Code of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

Previous NCD coding changes appear in ICD-10 quarterly updates that can be found at: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

EFFECTIVE DATE: January 1, 2018 - Unless Otherwise Noted
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 13, 2017- from Issuance for Local Edits; January 2, 2018 - Shared System Maintainers

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1875	Date: July 27, 2017	Change Request: 10184

SUBJECT: ICD-10 Coding Revisions to National Coverage Determinations (NCDs)

EFFECTIVE DATE: January 1, 2018 - Unless Otherwise Noted
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 13, 2017- from Issuance for Local Edits; January 2, 2018 - Shared System Maintainers

I. GENERAL INFORMATION

A. Background: This Change Request (CR) constitutes a maintenance update of International Code of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

Previous NCD coding changes appear in ICD-10 quarterly updates that can be found at: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs.

B. Policy: Edits to ICD-10, and other coding updates specific to NCDs, will be included in subsequent quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Please follow the link below for the NCD spreadsheets included with this CR:

https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10184.zip

Clarification: Coding (as well as payment) is a separate and distinct area of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Note: The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow Medicare Administrative Contractor (MAC) discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

Note/Clarification: Part A and Part B MACs (A/B MACs) shall complete all tasks that involve updates to local system edits/tables associated with the attached NCDs in this CR.

Note/Clarification: A/B MACs shall use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119. See latest CAQH CORE update. When denying claims associated with the attached NCDs, except where otherwise indicated. A/B MACs shall use:

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed

Advance Beneficiary Notice (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). For modifier GZ, use CARC 50 and Medicare Summary Notice (MSN) 8.81 per instructions in CR 7228/TR 2148.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10184.1	NCD160.18 Vagus Nerve Stimulation Contractors shall **CREATE** discretionary edits to bypass the NCD hard edit, if applicable, when 64568 (vagal nerve), 0466T (implant of hypoglossal nerve) and G47.33 (OSA) appear on a claim effective October 1, 2016. Contractors shall **REMOVE** TOB 11X, 73X. See spreadsheet.	X	X			X	X			
10184.2	NCD210.4.1 Counseling to Prevent Tobacco Use Contractors shall **DELETE** ICD-10 dx codes F17.200 and F17.201 effective October 1, 2015. FISS shall **END-DATE** any non-NCD reason codes effective October 1, 2015, and ensure all applicable criteria is included in the ICD-10 59XXX NCD reason codes. Contractors shall **ADD** ICD-10 dx codes F17.213, F17.218, F17.219, F17.223, F17.228, F17.229, F17.293, F17.298, F17.299 effective October 1, 2015. See spreadsheet.	X	X			X	X			
10184.3	NCD220.6.17 PET for Solid Tumors Contractors shall **ADD** ICD-10 dx codes C49.A1, C49.A2, C49.A3, C49.A4, C49.A5, C49.A9, R91.8 effective October 1, 2016. Contractors shall **DELETE** ICD-10 dx C79.51, C79.52, C80.0, C80.1 effective October 1, 2015.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Contractors shall **END-DATE**reference to and any edits for A9515, A9587, A9588 effective January 1, 2017. See spreadsheet.									
10184.4	NCD220.6.20 - PET Beta Amyloid in Dementia/Neurological Disorders Contractors shall **END-DATE**A9599 effective January 1, 2018. FISS shall **DELETE** logic for non-NCD reason codes effective October 1, 2015, and replace with 59CXX NCD reason codes. FISS shall **END-DATE** any non-NCD reason codes effective October 1, 2015, and ensure all applicable criteria is included in the ICD-10 59XXX NCD reason codes. **Note**: Updates made to the October quarterly IOCE, MPFS, and HCPCS are under separate CRs. See spreadsheet.	X	X			X	X			
10184.5	Contractors shall adjust any claims that are brought to their attention that were processed in error for any of the NCDs included in this CR.	X	X							
10184.6	Contractors shall use default CAQH CORE messages where appropriate: RARC N386 with CARC 50, 96, and/or 119. See latest CAQH CORE update. When denying claims associated with the attached NCDs, except where otherwise indicated.	X	X							
10184.6.1	A/B MACs shall use: Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and 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	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	file). For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148. NOTE: This replicates the note under the Policy section.									
10184.7	Contractors shall attend up to four 1-hour calls to conduct analysis and explore options to implement outstanding edit issues for the April 2018 release as they pertain to ICD-10 and NCDs. The scheduling of the calls will occur after this CR has been issued in final.	X	X			X	X		X	
10184.8	NCD210.13 Screening for Hepatitis C Virus FISS shall **DELETE** reason code 31834 provider liability. Spreadsheet updated with CR9200 edits. No action necessary. See spreadsheet.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10184.9	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Medicare Coverage) , Pat Brocato-Simons, 410-786-0261 or patricia.brocatosimons@cms.hhs.gov (Medicare Coverage)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 5

NCD:	160.18		
NCD Title:	Vagus Nerve Stimulation		
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part2.pdf		
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=230&ncdver=2&DocID=160.18&SearchType=Advanced&bc=IAAAAAgAAAAA&		
		ICD-10 CM	**ICD-10 DX Description**
		G40.011	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, with status epilepticus
		G40.019	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, without status epilepticus
		G40.111	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
		G40.119	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
		G40.211	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus
		G40.219	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
	NOTE: CPT 61885 (insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to a single electrode array) & 61886 (incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to 2 or more electrode arrays) are necessary in both NCD160.18 and 160.24. Adding the 3 dx codes from NCD160.24 (G20, G25.0, G25.2) to the list of dx for NCD160.18 for administrative/system purposes only should allow the CPT codes to be paid through the same edit.		

NCD:	160.18		
NCD Title:	Vagus Nerve Stimulation		
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part2.pdf		
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=230&ncdver=2&DocID=160.18&SearchType=Advanced&bc=IAAAAAgAAAAA&		
		ICD-10	**ICD-10 PCS Description**
		N/A	N/A

NCD:	160.18
NCD Title:	Vagus Nerve Stimulation (CR5612, CR7818, CR8691, CR9087, CR9252, CR9540, CR9751, CR10184)
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part2.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=230&ncdver=2&DocID=160.18&SearchType=Advanced&bc=IAAAAAgAAAAA&

Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**A/MACs & FISS: Eff**ective 7/1/99, VNS is R&N with payable dx for patients with medically refractory partial onset seizures for whom surgery is not recommended or for whom surgery has failed. RCs 59043/59044 need to be overridable when there is a payable dx present per First Coast. **NOTE:** Some of the CPT codes listed (for example generator programming codes) may be used for services beyond those addressed in this NCD; i.e., NCD230.18, SNS. A/MACs may allow for additional dx codes as necessary for these services when not doing so will conflict with other covered services unrelated to VNS. NOTE: 160.18 is only for refractory seizures - Parkinson's disease is non-covered, you do not need both refractory epilepsy and Parkinson's for coverage of VNS.	61885 64568 64569 64570 95974 95975	N/A	12X 13X 71X 77X 85X	0278 0360 036x 049x 051x 052x 076x 0949 096x 0975 0982	N/A	N/A	16.10	50	M38

NCD:	160.18
NCD Title:	Vagus Nerve Stimulation (CR5612, CR7818, CR8691, CR9087, CR9252, CR9540, CR9751, CR10184)
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part2.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=230&ncdver=2&DocID=160.18&SearchType=Advanced&bc=IAAAAAgAAAAA&

Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	**B/MACs & MCS: E**ffective 7/1/99, VNS is covered for patients with medically refractory partial onset seizures for whom surgery is not recommended or for whom surgery has failed. **NOTE:** Some of the CPT codes listed (for example generator programming codes) may be used for services beyond those addressed in this NCD; i.e., NCD230.18, SNS. MACs may allow for additional ICD-10 codes as necessary for these services when not doing so will conflict with other covered services unrelated to VNS. 160.18 is only for refractory seizures - Parkinson's disease is non-covered, you do not need both refractory epilepsy and Parkinson's for coverage of VNS.	61885 64568 64569 64570 95974 95975	N/A	N/A	N/A		N/A	14.9 15.4 15.20 16.10	50	N386

REVISION HISTORY

CR8691: Add all CPT codes from 160.18 in CR7818 except for expired CPT 61887 and 64573.
Add replacement codes 0312T-0317T.
Remove RARC M27 with CARC 50; not allowed per CORE.
Add Rule Description for Parts A & B from CR7818.
CR8691: Remove migraine ICD-9 (346.01-346.83) & ICD-10 (G43.111-G43.819). Per CMS, VNS is not appropriate for treatment of migraine at this time and is investigational only.
CR9087: CPT replacement codes 0312T-0317T removed since they represent stimulation of the gastric rather than cranial nerves.
CR9087: Add back ICD-10 codes G40.519 & G40.819 that were removed in error.
CR9087: Remove L8680, not payable by Medicare.
CR9252: Remove 'draft' from footer.
Remove L8685-L8688, no longer separately payable by Medicare, added agreed-upon language: dx code editing for both 160.18 & 160.24
Remove CPT/HCPCS codes 64590, 64595, C1767, C1778, L8681, L8682, L8683, L8689 from both FISS & MCS hard edits per Noridian suggestion and SSM approval. This removes any discrepancy with NCD230.18. Effective10/1/15, FISS to implement 4/4/16. TDL to follow.
Revise dx tab note and notes in rule descriptors to better clarify editing.
CR9252: Per First Coast, FISS RCs 59043/59044 need to be overridable when payable dx is present.
CR9540: Remove expired ICD-10 dx G40.819 and G40.519 effective for DOS on and after 10/1/15.
Ensure CPT 95970, 95971, 95974, 95975, 95978, 95979 included in local edits to eliminate discrepancy with NCD160.24 & 230.18. Released TDL 150563.
CR9751: Clarify HCPCS programming codes 95970, 95971, 95978, 95979, as well as CPT 61867, 61868, 61886, 61888, 64553 should be removed from FISS RCs 59039, 59040, 59041, 59042, 59043 and 59044, FISS to add 61885, MCS edit 012L effective 7/1/16 per instructions in CR9540 above. FISS RCs 59039-59044 can be reactivated with the implementation of this CR9751.
CR10184: MCS and FISS to create overridable discretionary edits to bypass the NCD hard edit when 64568 (vagal nerve), 0466T (implant of hypoglossal nerve) and G47.33 (OSA) appear on a claim effective 10/1/16. MACs to install follow-on discretionary edits as they deem appropriate.
TOB 11X and 72X removed from line 7.

NCD:	210.4.1		
NCD Title:	Counseling to Prevent Tobacco Use		
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf		
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=308&ncdver=1&DocID=210.4&SearchType=Advanced&bc=IAAAAAgAAAAA&		
		ICD-10 CM	**ICD-10 DX Description**
	CMS reserves the right to add or remove diagnoses codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy.	F17.210	Nicotine dependence, cigarettes, uncomplicated
		F17.211	Nicotine dependence, cigarettes, in remission
		F17.213	Nicotine dependence, cigarettes, with withdrawal
		F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
		F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
		F17.220	Nicotine dependence, chewing tobacco, uncomplicated
		F17.221	Nicotine dependence, chewing tobacco, in remission
		F17.223	Nicotine dependence, chewing tobacco, with withdrawal
		F17.228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
		F17.229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
		F17.290	Nicotine dependence, other tobacco product, uncomplicated
		F17.291	Nicotine dependence, other tobacco product, in remission
		F17.293	Nicotine dependence, other tobacco product, with withdrawal
		F17.298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
		F17.299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
		T65.211A	Toxic effect of chewing tobacco, accidental (unintentional), initial encounter
		T65.212A	Toxic effect of chewing tobacco, intentional self-harm, initial encounter
		T65.213A	Toxic effect of chewing tobacco, assault, initial encounter
		T65.214A	Toxic effect of chewing tobacco, undetermined, initial encounter
		T65.221A	Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter
		T65.222A	Toxic effect of tobacco cigarettes, intentional self-harm, initial encounter
		T65.223A	Toxic effect of tobacco cigarettes, assault, initial encounter
		T65.224A	Toxic effect of tobacco cigarettes, undetermined, initial encounter
		T65.291A	Toxic effect of other tobacco and nicotine, accidental (unintentional), initial encounter
		T65.292A	Toxic effect of other tobacco and nicotine, intentional self-harm, initial encounter
		T65.293A	Toxic effect of other tobacco and nicotine, assault, initial encounter
		T65.294A	Toxic effect of other tobacco and nicotine, undetermined, initial encounter
		Z87.891	Personal history of nicotine dependence

NCD:	210.4.1		
NCD Title:	Counseling to Prevent Tobacco Use		
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf		
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=308&ncdver=1&DocID=210.4&SearchType=Advanced&bc=IAAAAAgAAAAA&		
		ICD-10 PCS	**ICD-10 PCS Description**
		N/A	N/A

NCD:	210.4.1
NCD Title:	Counseling to Prevent Tobacco Use (CR7133, CR8197, CR9631, CR10184)
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=308&ncdver=1&DocID=210.4&SearchType=Advanced&bc=IAAAAAgAAAAA&

Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**FISS, A/MACs** shall pay for counseling to prevent tobacco use services for hospitalized and OP Medicare patients containing HCPCS G0436 or G0437 (through 9/30/16, beginning 10/1/16 use CPT 99406 & 99407) with approved dx as follows: 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. **A/MACs** shall pay HCPCS codes with noted revenue codes. **A/MACs** shall accept counseling to prevent tobacco use services HCPCS codes G0436 and G0437 with revenue code 0942 on claims with noted TOBs. **A/MACs** shall accept revenue code 052X for counseling to prevent tobacco use services HCPCS codes G0436 and G0437 on noted TOBs. **A/MACs** shall accept revenue code 0510 for counseling to prevent tobacco use services HCPCS codes G0436 and G0437 on IHS claims. **CWF** shall deny counseling to prevent tobacco use services (HCPCS G0436, G0437 through 9/30/16; effective 10/1/16 use CPT codes 99406 & 99407) that exceed a combined total of 8 sessions within a 12-month period. **NOTE:** In calculating a 12-month period, 11 months must pass following the month in which the 1st Medicare covered cessation counseling session was performed. Section 4104 of ACA provided for a waiver of the Medicare coinsurance and Part B deductible requirements for this service effective on or after 1/1/11. **Copayment/coinsurance waived; Deductible waived for HCPCS G0436 & G0437 through 9/30/16, for CPT codes 99406 & 99407 effective 10/1/16.**	CPT 99406 & 99407 replace G0436 & G0437 effective 10/1/16. HCPCS G0436 & G0437 deleted 9/30/16	2 cessation attempts per year; each attempt includes max of 4 intermediate or intensive sessions, up to 8 sessions in 12-month period	12X 13X 22X 23X 34X 71X 77X 85X	096X, 097X, or 098X on TOB 85X Method II under MPFS. 0942 on TOBs 12X, 13X, 22X, 23X, 34X, and 85X. 052X on TOBs 71X and 77X. 0510 on IHS claims	N/A	N/A	15.4 15.20 20.5 21.21	11,119,167 ---------- 50	N386 ------- M76
Part A	**A/MACs** shall allow payment for a medically necessary evaluation and management (E/M) service on same day as counseling to prevent tobacco use service when it is clinically appropriate. Providers shall report an E/M service with modifier -25 to indicate that E/M service is a separately identifiable service from counseling to prevent tobacco use service.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

NCD:	210.4.1
NCD Title:	Counseling to Prevent Tobacco Use (CR7133, CR8197, CR9631, CR10184)
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=308&ncdver=1&DocID=210.4&SearchType=Advanced&bc=IAAAAAgAAAAA&

Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	**MCS, B/MACs** shall pay for counseling to prevent tobacco use services for hospitalized and OP Medicare patients containing HCPCS G0436 or G0437 (through 9/30/16, beginning 10/1/16 use CPT 99406 & 99407) with approved dx as follows: 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. **CWF** shall deny counseling to prevent tobacco use services (HCPCS G0436, G0437 (through 9/30/16; effective 10/1/16 use CPT codes 99406 & 99407) that exceed a combined total of 8 sessions within a 12-month period. **NOTE**: In calculating a 12-month period, 11 months must pass following the month in which the 1st Medicare covered cessation counseling session was performed. Section 4104 of ACA provided for a waiver of the Medicare coinsurance and Part B deductible requirements for this service effective on or after 1/1/11 **Copayment/coinsurance waived; Deductible waived for HCPCS G0436 & G0437 through 9/30/16, for CPT codes 99406 & 99407 effective 10/1/16.**	CPT 99406 & 99407 replaces G0436 & G0437 effective 10/1/16. HCPCS G0436 & G0437 deleted 9/30/16	2 cessation attempts per year; each attempt includes max of 4 intermediate or intensive sessions, up to 8 sessions in 12-month period	N/A	N/A	N/A	N/A	15.4 15.20 20.5 21.21	11,119,167 ---------- 50	N386 ------- M76
Part B	**B/MACs** shall allow payment for a medically necessary E/M service on same day as counseling to prevent tobacco use service when it is clinically appropriate. Providers shall report E/M service with modifier -25 to indicate that E/M service is a separately identifiable service from counseling to prevent tobacco use service.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

CR10184	Delete ICD-10 dx codes F17.200 and F17.201 effective 10/1/15. Add ICD-10 dx codes F17.213, F17.218, F17.219, F17.223, F17.228, F17.229, F17.293, F17.298, F17.299 effective 10/1/15. MCS 048L to be updated. FISS to end-date non-NCD RC 32373 for HCPCS G0436/G0437 TOBs and CREATE 59XXX NCD RCs that also include 99406/99407 effective 9/30/15. FISS to end-date non-NCD RC 32374-32378, 34910 for revenue codes and CREATE 59XXX NCD RCs effective 10/1/15. FISS to end-date non-NCD RC 32382/32383 to not validate dx codes effective 10/1/15. FISS will end date any non-NCD RCs effective 10/1/15 and ensure all applicable criteria is included in the ICD-10 NCD RCs.
CR9631	CPT codes 99406 & 99407 replace HCPCS G0436 & G0437 effective 10/1/16. All other existing edits remain for this service. Update CARC-RARC messages.

NCD:	210.13
NCD Title:	Screening for Hepatitis C Virus
IOM:	http://cms.hhs.gov/medicare-coverage-database/details/nca-decision-
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.pdf

		ICD-10 CM	ICD-10 DX Description
			Primary diagnosis
		Z72.89	Other problems related to lifestyle
			Secondary diagnosis required for yearly screening
		F19.20	Other psychoactive substance dependence, uncomplicated
			Diagnosis for no risk cohort born between 1945-1965
		Z11.59	Encounter for screening for other viral disease

NCD:	210.13		
NCD Title:	Screening for Hepatitis C Virus		
IOM:	http://cms.hhs.gov/medicare-coverage-database/details/nca-decision-		
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.pdf		
		ICD-10 PCS	**ICD-10 PCS Description**
		N/A	

NCD:	210.13 (CR8871, CR9200, CR10086, CR10184)									
NCD Title:	Screening for Hepatitis C Virus in Adults									
IOM:	http://cms.hhs.gov/medicare-coverage-database/details/nca-decision-									
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.pdf									
Part A	**Rule Description Part A**	**Proposed HCPCS/CPT Part A**	**Frequency Limitations**	**TOB (Part A)**	**Revenue Code Part A**	**Modifier Part A**	**Provider Specialty**	**Proposed MSN Message Part A**	**Proposed CARC Message Part A**	**Proposed RARC Message Part A**
Part A	Effective for claims with DOS 6/2/14, CMS will cover screening with FDA-approved/cleared tests for HCV when ordered by the beneficiary's primary care physician/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 screening test is covered for adults at high risk for Hepatitis C Virus infection. "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. -Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test	G0472	Annually for persons with current illicit injection drug use	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Part A	**A/MAC, FISS:** Effective for claims with DOS 6/2/14, shall recognize HCPCS G0472, HCV screening, as a covered technical service - there is no professional payment. **NOTE:** HCPCS, G0472, HCV screening, will be in the 1/15 MPFSDB and IOCE updates, with an effective date of 6/2/14. **A/MAC, FISS, CWF:** Effective for DOS 6/2/14, beneficiary coinsurance and deductibles do not apply to claim lines containing HCPCS G0472.	G0472	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Part A	**CWF:** shall identify the following institutional claims as facility fee claims for screening services: •TOB 13X Hospital Outpatient Departments •TOB 14X Non-Patient Laboratory Specimens •TOB 85X Critical Access Hospitals (CAHs) **when the revenue code is not 096X, 097X or 098X**	G0472	N/A	13X 14X 85X	N/A	N/A	N/A	N/A	N/A	N/A
Part A	**A/MAC, FISS:** pay HCPCS G0472 on TOB 13X based on MPFS, TOB 14X under the clinical lab fee schedule, TOB 85X based on reasonable cost.	G0472	N/A	13X 14X	N/A	N/A	N/A	N/A	N/A	N/A

NCD:	210.13 (CR8871, CR9200, CR10086, CR10184)									
NCD Title:	Screening for Hepatitis C Virus in Adults									
IOM:	http://cms.hhs.gov/medicare-coverage-database/details/nca-decision-									
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.pdf									
Part A	**A/MAC, FISS:** shall deny line-items on claims for HCV screening HCPCS G0472 when submitted on TOBs other than 13X, 14X, or 85X. **NOTE:** While RHCs and FQHCs cannot bill for HCV screening services, this does not prevent HCV screening services from being provided to patients at RHCs and FQHCs. **NOTE:** CAHs, TOB 85X, are valid facilities for HCV screening services. However, G0472 is a technical service only, there is no professional payment to CAHs for HCV screening (see CR9200). **NOTE:** for modifier GZ, use CARC 50 & MSN 8.81 per instructions in CR7228/TR2148	G0472	N/A	13X 14X 85X	N/A	GZ	N/A	21.25	170	N95
Part A	**FISS, CWF:** A single screening test is covered for adults who do not meet the high risk as defined above, but who were born from 1945 through 1965, and HCPCS G0472 is accompanied by ICD-10 dx Z11.59 (addition of dx code eff 10/1/17). NOTE: This edit shall be overridable.	G0472	Once per lifetime	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Part A	**A/MAC**: Effective for claims with DOS 6/2/14, shall deny line-items on claims with HCPCS G0472 and ICD-10 dx Z11.59 reported more than once in a lifetime for beneficiaries who do not meet the definition of high risk but were born from 1945 through 1965 using the following messages in addition to 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 per CR7228/TR2148.	G0472	Once per lifetime	N/A	N/A	N/A	N/A	15.19 15.20	119	N386
Part A	**A/MAC:** shall line-item deny claims noted in 8871-04.5 for initial high risk without the appropriate HCPCS and diagnosis codes using the following messages:	G0472	N/A	N/A	N/A	N/A	N/A	15.19 15.20	119	N386
Part A	**A/MAC, CWF:** Effective for claims with DOS 6/2/14, shall allow payment for one annual HCV screening in adults at high risk who have had continued illicit injection drug use since the prior negative screening test when the claim is submitted with the following: • HCPCS G0472, • ICD-10 dx Z72.89, and • ICD-10 dx F19.20 **NOTE:** This edit shall be overridable. **NOTE:** 11 full months must elapse following the month in which the last negative HCV screening took place	G0472	Annually for persons with current illicit injection drug use	13X 14X 85X	N/A	GZ	NA	N/A	N/A	N/A

NCD:	210.13 (CR8871, CR9200, CR10086, CR10184)									
NCD Title:	Screening for Hepatitis C Virus in Adults									
IOM:	http://cms.hhs.gov/medicare-coverage-database/details/nca-decision-									
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.pdf									
Part A	**A/MAC**: Effective for claims with DOS 6/2/14, shall deny line-items on claims for HCPCS G0472, HCV screening, that do not include the required coding in 8871-04.6 for continued illicit injection drug use using the following messages in addition to 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 per CR7228/TR2148.	G0472	N/A	N/A	N/A	N/A	N/A	15.19 15.20	167	N386
	FISS, CWF: Effective for claims with DOS 6/2/14, FISS and CWF shall create overridable edits that line-item deny HCPCS G0472 HCV screening for beneficiaries born prior to 1945 and after 1965 without any risk; i.e., absent ICD-10 Z72.89 and F19.20 (see CR9200). **A/B MAC:** Shall use the following messages when line-item denying G0472 HCV screening services noted above (see CR9200):	G0472	NA	NA	NA	NA	NA	15.19 15.20	96	N386
Part A	**A/MAC, CWF:** Effective for claims with DOS 6/214, shall allow payment for one HCV screening test for beneficiaries initially determined at high risk, when the claim is submitted with the following: • HCPCS G0472, and • ICD-10 dx Z72.89	G0472	Annually for persons who have current illicit injection drug use	N/A	N/A	GZ	N/A	N/A	N/A	N/A

NCD:	210.13 (CR8871, CR9200, CR10086, CR10184)
NCD Title:	Screening for Hepatitis C Virus in Adults
IOM:	http://cms.hhs.gov/medicare-coverage-database/details/nca-decision-
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.pdf

Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	Effective for claims with DOS 6/2/14, CMS will cover screening for HCV with the appropriate FDA-approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with CLIA regulations, when ordered by the beneficiary's primary care physician/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 screening test is covered for adults at high risk for Hepatitis C Virus infection. "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. -Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.	G0472	Annually for persons with current illicit injection drug use	11 22 49 50 71 72 81	N/A	GZ	01 08 11 16 37 38 42 50 89 97	N/A	N/A	N/A
Part B	**B/MAC:** Effective for claims with DOS 6/2/14, shall recognize HCPCS G0472, HCV screening, as a covered service. **NOTE:** HCPCS, G0472, HCV screening, will be in the 1/15 MPFSDB and IOCE updates, with an effective date of 6/2/14. **B/MAC, CWF:** Effective for DOS 6/2/14, beneficiary coinsurance and deductibles do not apply to claim lines containing HCPCS G0472.	G0472	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Part B	**B/MAC, CWF:** Effective for claims with DOS 6/2/14, shall allow payment for one annual HCV screening in adults at high risk who have had continued illicit injection drug use since the prior negative screening test when the claim is submitted with the following: • HCPCS G0472, • ICD-10 dx Z72.89, and • ICD-10 dx F19.20 **NOTE:** This edit shall be overridable. **NOTE:** 11 full months must elapse following the month in which the last negative HCV screening took place	G0472	Annually for persons who have current illicit injection drug use	11 22 49 50 71 72 81	N/A	GZ	01 08 11 16 37 38 42 50 89 97	N/A	N/A	N/A

NCD:	210.13 (CR8871, CR9200, CR10086, CR10184)									
NCD Title:	Screening for Hepatitis C Virus in Adults									
IOM:	http://cms.hhs.gov/medicare-coverage-database/details/nca-decision-									
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.pdf									
Part B	**B/MAC:** shall deny line items with HCV screening HCPCS G0472 and provider specialty codes other than those listed in 8871-04.2 (8871-04.2 MCS edit). Group Code CO (contractual obligation). 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	G0472	N/A	N/A	N/A	GZ	01 08 11 16 37 38 42 50 89 97	21.18	184	N574
Part B	**B/MAC:** Effective for claims with DOS 6/2/14, shall deny line-items on claims with HCPCS G0472 and ICD-10 dx Z11.59 reported more than once in a lifetime for beneficiaries who do not meet the definition of high risk but were born from 1945 through 1965 using the following messages along with 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 per CR7228/TR2148.	G0472	N/A	N/A	N/A	N/A	N/A	15.19 15.20	167	N386
Part B	**B/MAC, CWF:** Effective for claims with DOS 6/214, shall allow payment for one HCV screening test for beneficiaries initially determined at high risk, when the claim is submitted with the following: • HCPCS G0472, and • ICD-10 dx Z72.89	G0472	Annually for persons with current illicit injection drug use	N/A	N/A	GZ	N/A	N/A	N/A	N/A
Part B	**B/MAC, MCS:** Effective for claims with DOS 6/2/14, shall pay claims for screening for HCPCS G0472 when ordered by a primary care practitioner (physician or non-physician) with any of the following specialty codes on the provider's enrollment record. (MCS edit 001G no changes needed)	G0472	Once per lifetime OR annually for persons with current illicit injection drug use	11 22 49 50 71 72 81	N/A	GZ	01 08 11 16 37 38 42 50 89 97	N/A	N/A	N/A
Part B	**B/MAC:** shall deny line items with HCPCS G0472 and specialty codes other than those listed with the following and 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 per CR7228/TR2148.	G0472	N/A	N/A	N/A	GZ		21.18	184	N574

NCD:	210.13 (CR8871, CR9200, CR10086, CR10184)									
NCD Title:	Screening for Hepatitis C Virus in Adults									
IOM:	http://cms.hhs.gov/medicare-coverage-database/details/nca-decision-									
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.pdf									
Part B	**B/MAC, CWF:** Effective for claims with DOS 6/214, shall allow one HCV screening per lifetime, HCPCS G0472, for adult beneficiaries who were born from 1945 through 1965 who are not considered high risk when HCPCS G0472 is accompanied by ICD-10 dx Z11.59 (dx code addition eff 10/1/17). **NOTE:** This edit shall be overridable	G0472	Once per lifetime	11 22 49 50 71 72 81	N/A	N/A	N/A	N/A	N/A	N/A
Part B	**B/MAC, CWF:** Effective for claims with DOS 6/2/14, shall allow payment for one HCV screening test for beneficiaries initially determined at high risk, when the claim is submitted with the following: • HCPCS G0472, and • ICD-10 dx Z72.89 **NOTE:** This edit shall be overridable	G0472	Annually for persons with current illicit injection drug use	11 22 49 50 71 72 81	N/A	N/A	N/A	N/A	N/A	N/A
Part B	**B/MAC:** shall line-item deny claims noted in 8871-04.5 for initial high risk without the appropriate HCPCS and dx codes using the following messages:	G0472	N/A	N/A	N/A	N/A	N/A	15.19 15.20	119	N386
Part B	**B/MAC:** Effective for claims with DOS 6/214, shall deny line-items on claims for HCPCS G0472, HCV screening, that do not include the required coding in 8871-04.6 for continued illicit injection drug use using the following messages in addition to 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 per CR7228/TR2148.	G0472	N/A	N/A	N/A	N/A	N/A	15.19 15.20	119	N386
	B/MAC: Effective for claims with DOS 6/2/14, shall line-item deny HCPCS G0472 HCV screening for beneficiaries born prior to 1945 and after 1965 without any risk; i.e., absent ICD-10 Z72.89 and F19.20 using the following messages (see CR9200):	G0472	NA	NA	NA	NA	NA	15.19 15.20	96	N386
Part B	**B/MAC:** shall deny line-items with HCPCS G0472 and POS codes other than those listed with the following messages.	G0472	N/A	11 22 49 50 71 72 81	N/A	N/A	N/A	21.25	171	N428

NCD:	210.13 (CR8871, CR9200, CR10086, CR10184)
NCD Title:	Screening for Hepatitis C Virus in Adults
IOM:	http://cms.hhs.gov/medicare-coverage-database/details/nca-decision-
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.pdf
Revision notes	**CR9200:** Remove TOB 71X, 77X, & 85X when revenue code is 096X, 097X, 098X. POS 59, 72 & 81, updated 04.8.1, 04.10 & 04.10.2. Add POS 50, modified 8871-04.8.1, 04.10 & 04.10.2 **CR10086:** Clarify correct MCS edit line 28. Add TOB 14X to spreadsheet (edit already performed in CR9360). Remove provider specialty codes, line 16, not applicable to Part A. Add ICD-10 dx Z11.59 to G0472 for 1945-1965 birth cohorts per CMS effective 10/1/17. MACs to bypass FISS RC 5303 if ICD-10 dx is not present when birth year is 1945-1965 for DOS on or after 10/1/17. FISS to permanently disable RC 31833, 39920, 39921, 39922, replace with new 59XXX RCs for MAC-controlled discretionary dx code edit. MACs to set-up ECPS event to suspend and deny with new 59XXX RCs. Remove ICD-9 dx codes. **CR10184:** FISS to permanently disable RC 31834 provider liability. Spreadsheet updated to align with edits in CR9200, see lines 8, 11, 17, and 33. Edits performed in CR9200.

NCD:	220.6.20
NCD Title:	Beta Amyloid PET for Dementia and Neurodegenerative Disease (CR8526, CR9751 CRXXXX
IOM:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1753OTI
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-

ICD-10 CM	ICD-10 DX Description
	Primary Diagnosis or Secondary
Z00.6	Encounter for examination for normal comparison and control in clinical research program
	Additional diagnosis required in addition to Z00.6
F03.90	Unspecified dementia without behavioral disturbance
F03.91	Unspecified dementia with behavioral disturbance
F01.50	Vascular dementia without behavioral disturbance
F01.51	Vascular dementia with behavioral disturbance
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
G31.01	Pick's disease
G31.09	Other frontotemporal dementia
G31.85	Corticobasal degeneration
G31.83	Dementia with Lewy bodies
G31.84	Mild cognitive impairment, so stated
R41.1	Anterograde amnesia
R41.2	Retrograde amnesia
R41.3	Other amnesia (amnesia NOS, memory loss NOS)

)
N.pdf

NCD:	220.6.20		
NCD Title:	Beta Amyloid PET for Dementia and Neurodegenerative Disease (CR8526, CR9751 CRXXXX)		
IOM:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1753OTN.pdf		
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=288&ncdver=3&bc=AgAAgAAAAAAAAA%3d%3d&		
		ICD-10 PCS	**ICD-10 PCS Description**
		N/A	N/A

NCD:	220.6.20
NCD Title:	Beta Amyloid PET for Dementia and Neurodegenerative Disease (CR8526, CR9751 CR10184)
IOM:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1753OTN.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=265&NcaName=Beta+Amyloid+Positron+Emission+Tomography+in+Dementia+and+Neurodegenerative+Disease&bc=AiAAAAAACAAAAA%3d%3d&

Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**A/MAC, FISS:** One of two PET imaging codes shall be required and one HCPCS dx radiopharmaceutical must be billed on claim. All codes relative to a clinical trial dx Z00.6, Q0 modifier, NCT number, condition code 30, value code D4 (new FISS RC will require) must all be on claim along with an additional, approved diagnosis.	78811 or 78814 and A9586 or Q9982 or Q9983	NA	NA	NA	Q0	N/A	15.20 15.4 16.77	16	M20 M44 M49
Part A	**CWF, FISS**: For claims with DOS on or after 9/27/13, CWF shall deny/reject claims for more than one PET Aβ scan, HCPCS A9586 (effective 1/1/13), Q9982, or Q9983 (effective 7/1/16) in a patient's lifetime. **NOTE:** This edit shall be overridable.	78811 or 78814 and A9586 or Q9982 or Q9983	1 per patient lifetime	NA	NA	NA	NA	20.12	149	N587
Part A	**A/MAC:** Shall identify claims with TOB 85X when revenue code is 096X, 097X, or 098X as professional claims.	78811 or 78814 and A9586 or Q9982 or Q9983	NA	85X	096X 097X 098X	NA	NA	NA	NA	NA
Part A	Florbetapir F18 NCD # 0002-1200-01 may be listed on claim for better drug identification.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

NCD:	220.6.20
NCD Title:	Beta Amyloid PET for Dementia and Neurodegenerative Disease (CR8526, CR9751 CR10184)
IOM:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1753OTN.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=265&NcaName=Beta+Amyloid+Positron+Emission+Tomography+in+Dementia+and+Neurodegenerative+Disease&bc=AiAAAAAACAAAAA%3d%3d&

Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	**B/MAC, MCS**: One of two PET imaging codes is required and one HCPCS dx radiopharmaceutical must be billed on claim. All codes relative to a clinical trial include dx Z00.6, -Q0 modifier, NCT number, along with an additional, approved dx.	78811 or 78814 and A9586 or Q9982 or Q9983	NA	N/A	N/A	Q0	N/A	15.20 15.4 16.77	16	M64 M20
Part B	Florbetapir F18 NCD # 0002-1200-01 may be listed on claim for better drug identification.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Revision Explanation									
	Add A9599, add RARC N517, N519, N586, CARC 149, MSN 20.12, TOB 85X , rev codes 096X, 097X, 098X and additional dx requirement - see dx tab.									
	Change A/B MACs to A/MACs or B/MACs for clarity.									
	CR9751: Effective 1/1/16 add C9458 & C9459 to A/MAC instructions. 6/30/16 end-date C9458 & C9459.									Effective
	New FISS RC to require value code D4.									
	Add new codes Q9982 and Q9983 effective 7/1/16. MCS edit 010K & 011K. CARC/RARC messages per CORE.									Revise
	CR10184: End-date A9599 NOC code effective 1/1/18. audit 010K/011K to be updated. FISS to delete logic for non-NCD RCs and replace w/59CXX RCs effective 10/1/15. to end-date non-NCD RC 32718 effective 10/1/15 and create new 59XXX NCD RCs. to delete RC 39906.									MCS FISS FISS

NCD:	220.6.17		
NCD Title:	Positron Emission Tomography (FDG) for Oncologic Conditions		
IOM:	https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=331&ncdver=4&bc=AgAAQAAAAAAAAA%3d%3d&		
MCD:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3162CP.pdf		
		ICD-10 CM	**ICD-10 DX Description**
			NOTE: Refer to the following link for a list of appropriate diagnosis codes:
			http://www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/PETforSolidTumorsOncologicDxCodesAttachment_NCD220_6_17.pdf
			CMS reserves the right to add or remove diagnoses codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy.

NCD:	220.6.17		
NCD Title:	Positron Emission Tomography (FDG) for Oncologic Conditions		
IOM:	https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=331&ncdver=4&bc=AgAAQAAAAAAAAA%3d%3d&		
MCD:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3162CP.pdf		
		ICD-10 PCS	**ICD-10 PCS Description**
		N/A	

NCD:	220.6.17									
NCD Title:	Positron Emission Tomography (FDG) for Oncologic Conditions	(CR6632, CR7125, CR7148, CR8381, CR8468, CR8739, CR9751, CR9861, CR10086, CR10184)								
IOM:	https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=331&ncdver=4&bc=AgAAQAAAAAAAAA%3d%3d&									
MCD:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3162CP.pdf									

Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**A/MACs:** Effective for claims with DOS on or after 4/3/09, shall accept FDG PET claims billed to inform initial tx strategy with one of the following PET CPT codes AND modifier –PI: 78811, 78812, 78813, 78814, 78815, 78816 and FDG PET HCPCS radiopharmaceutical A9552.	**SCAN** 78608=PET brain **OR** 78811=PET head/neck chest **OR** 78812=PET skull base to mid-thigh **OR** 78813=PET whole body **OR** 78814=PET/CT head/neck chest **OR** 78815=PET/CT skull base to mid-thigh **OR** 78816=PET/CT whole body **AND** **RADIO** A9552	Once per initial tx -PI	N/A	N/A	PI	N/A	23.17	50	M64
Part A	**A/MACs:** Effective for claims with DOS on or after 4/3/09, shall accept FDG PET claims with modifier –PS for the subsequent treatment strategy for solid tumors using one of the CPT codes AND a cancer diagnosis code AND FDG PET HCPCS radiopharmaceutical A9552. (See DX Tab/link)	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	3 per -PS	N/A	N/A	PS	N/A	23.17	50	M64

NCD:	220.6.17									
NCD Title:	Positron Emission Tomography (FDG) for Oncologic Conditions	(CR6632, CR7125, CR7148, CR8381, CR8468, CR8739, CR9751, CR9861, CR10086, CR10184)								
IOM:	https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=331&ncdver=4&bc=AgAAQAAAAAAAAA%3d%3d&									
MCD:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3162CP.pdf									
Part A	**A/MACs:** Effective for claims with DOS on or after 6/11/13, shall pay oncologic FDG PET claims for subsequent management, identified by one of the CPT codes 78811, 78812, 78813, 78814, 78815, or 78816, modifier –PS, FDG PET radio A9552, and the same cancer dx code (see attachment A on ICD Dx Tab), which exceed 3 FDG PET scans when the -KX modifier is included on the claim line. (The use of the -KX modifier attests that: 1) the requirements specified in the MACs' medical policy have been met, and, 2) the claim is for >3 FDG oncologic PET scans.)	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	Over 3 during - PS without - KX	N/A	N/A	PS KX	N/A	23.17	50	M64
Part A	**CWF** shall create two edits for oncologic FDG PET claims to reject to contractors when a beneficiary has reached 4 or greater FDG PET scans for subsequent tx strategy (-PS) for the same cancer dx and the -KX modifier is not included on the claim line. -Edit 1 will set when an incoming FDG PET scan claim contains a unit field with more than 3, or the incoming claim FDG PET scan claim contains more than 3 FDG PET scans detail lines with the same dx. -Edit 2 will set when the FDG PET scans (-PS) on the incoming claim added to the FDG Pet scan services posted to the auxiliary file equal to more than 3 services for the same dx.	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	4 per -PS Tx	N/A	N/A	PS KX	N/A	23.17	50	M64
Part A	**CWF** shall allow oncologic FDG PET scan claims to begin a new count with each subsequent tx strategy (-PS) and a different/new cancer dx than what is present in history for that beneficiary. **NOTE:** The presence or absence of an initial tx strategy (-PI) oncologic FDG PET claim in a beneficiary's record does not alter the count of the subsequent tx strategy (-PS) claims. When applying frequency limitations to each oncologic FDG PET claim for subsequent tx strategy (-PS), CWF shall allow both a claim for the professional service and a claim for a facility fee. CWF shall also count 1 PROF, 1 TECH for each global claim received.	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	3 per -PS	N/A	N/A	PS	N/A	23.17	50	M64
Part A	**CWF** shall identify the following institutional claims as facility fee claims for oncologic FDG PET services: ●TOB 13X ●TOB 85X when the revenue code is not 096X, 097X or 098X	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	N/A	13X 85X	096X 097X 098X	N/A	N/A	N/A	N/A	N/A

NCD:	220.6.17									
NCD Title:	Positron Emission Tomography (FDG) for Oncologic Conditions	(CR6632, CR7125, CR7148, CR8381, CR8468, CR8739, CR9751, CR9861, CR10086, CR10184)								
IOM:	https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=331&ncdver=4&bc=AgAAQAAAAAAAAA%3d%3d&									
MCD:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3162CP.pdf									
Part A	**A/MACs** shall deny subsequent tx strategy (-PS) claims for oncologic FDG PET scans which exceed 3 when a -KX modifier is not included on the claim line using the following: -Edit 1 -will set when an incoming FDG PET scan claim (PS) contains a unit field with more than three (3), or the incoming claim FDG PET scan claim (PS) contains more than three (3) FDG PET scans (PS) detail lines with the same dx. **AND** -Edit 2 – will set when the FDG PET scans (PS) on the incoming claim added to the FDG Pet scan (PS) services posted to the auxiliary file equal more than three (PS) services for the same dx.	**SCAN** 78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** **RADIO** A9552	Over 3 during - PS without - KX	N/A	N/A	KX	N/A	23.17	96	N386

NCD:	220.6.17									
NCD Title:	Positron Emission Tomography (FDG) for Oncologic Conditions	(CR6632, CR7125, CR7148, CR8381, CR8468, CR8739, CR9751, CR9861, CR10086, CR10184)								
IOM:	https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=331&ncdver=4&bc=AgAAQAAAAAAAAA%3d%3d&									
MCD:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3162CP.pdf									

Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	**B/MACs:** Effective for claims with DOS on or after 4/3/09, shall accept FDG PET claims billed to inform initial tx strategy with one of the following PET CPT codes AND modifier –PI: 78811, 78812, 78813, 78814, 78815, 78816 and FDG PET HCPCS radiopharmaceutical A9552.	**SCAN** 78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** **RADIO** A9552	N/A	N/A	N/A	PI	N/A	23.17	96	N56 N386
Part B	**B/MACs:** Effective for claims with DOS on or after 4/3/09, shall accept FDG PET claims with modifier –PS for subsequent tx strategy for solid tumors using one of the CPT codes, FDG PET radio A9552, AND a cancer dx code.	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	3 per -PS	N/A	N/A	PS	N/A	23.17	96	N386
Part B	**B/MACs** Effective for claims with DOS on or after 6/11/13, shall pay oncologic FDG PET claims for subsequent management identified by one of the following CPT codes 78811, 78812, 78813, 78814, 78815, or 78816, modifier –PS, FDG PET radio A9552, and the same cancer dx code (See Attachment A on ICD Dx Tab), which exceed 3 FDG PET scans when the -KX modifier is included on the claim line. (The use of the -KX modifier attests that: 1) the requirements specified in the MACs' medical policy have been met, and, 2) the claim is for >3 FDG oncologic PET scans.).	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	3 per -PS	N/A	N/A	PS KX	N/A	23.17	273	N386 N435
Part B	**CWF** shall create two edits for oncologic FDG PET claims to reject to contractors when a beneficiary has reached 4 or greater FDG PET scans for subsequent tx strategy (-PS) for the same cancer dx and the -KX modifier is not included on the claim line. -Edit 1 will set when an incoming FDG PET scan claim (-PS) contains a unit field with more than 3, or the incoming claim FDG PET scan claim contains more than 3 FDG PET scan detail lines with the same dx. -Edit 2 will set when the FDG PET scans (-PS) on the incoming claim added to the FDG Pet scan services posted to the auxiliary file equal more than 3 -PS services for the same dx.	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	3 per -PS	N/A	N/A	PS KX	N/A	23.17	273	N386 N435

NCD:	220.6.17									
NCD Title:	Positron Emission Tomography (FDG) for Oncologic Conditions	(CR6632, CR7125, CR7148, CR8381, CR8468, CR8739, CR9751, CR9861, CR10086, CR10184)								
IOM:	https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=331&ncdver=4&bc=AgAAQAAAAAAAAA%3d%3d&									
MCD:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3162CP.pdf									
Part B	**CWF** shall allow oncologic FDG PET scan claims to begin a new count with each subsequent tx strategy (-PS) and a different/new cancer dx than what is present in history for that beneficiary. **NOTE:** The presence or absence of an initial tx strategy (-PI) oncologic FDG PET claim in a beneficiary's record does not alter the count of the subsequent tx strategy (-PS) claims. When applying frequency limitations to each oncologic FDG PET claim for subsequent tx strategy (-PS), **CWF** shall allow both a claim for the professional service and a claim for a facility fee. CWF shall also count 1 PROF, 1 TECH for each global claim received.	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	N/A	N/A	N/A	PS	N/A	23.17	273	N386 N435
Part B	**CWF** shall identify all other oncologic FDG PET scan claims as professional service claims for screening services (professional claims and institutional claims with TOB 85X when the revenue code is 096X, 097X, or 098X).	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	N/A	85X	096X 097X 098X	N/A	N/A	N/A	N/A	N/A
Part B	**CWF** shall identify the TECH (-TC) and PROF (-26) modifiers on claims for oncologic FDG PET services for physician claims. The absence of both the modifiers (TC and 26) qualifies the claim as global for physicians. **HUBC** claims received without both the -TC and -26 modifier will alert **CWF** that both components of the service have been received.	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	N/A	N/A	N/A	TC 26	N/A	23.17	N/A	N/A
Part B	**B/MACs** shall deny subsequent tx strategy (-PS) claims for oncologic FDG PET scans which exceed 3 when a -KX modifier is not included on the claim line using the following: -Edit 1 -will set when an incoming FDG PET scan claim (PS) contains a unit field with more than three (3), or the incoming claim FDG PET scan claim (PS) contains more than three (3) FDG PET scans (PS) detail lines with the same dx. -Edit 2 – will set when the FDG PET scans (PS) on the incoming claim added to the FDG Pet scan (PS) services posted to the auxiliary file equal more than three (PS) services for the same dx.	78608 78811 78812 78813 78814 78815 **OR** 78816 **AND** A9552	Over 3 during PS without KX	N/A	N/A	KX	N/A	23.17	273	N386 N435
Revision										
	CR9751: Add additional radiopharmaceutical C9461 Choline C-11 to policy effective 4/1/2016.									

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NCD Title:	Positron Emission Tomography (FDG) for Oncologic Conditions (CR6632, CR7125, CR7148, CR8381, CR8468, CR8739, CR9751, CR9861, CR10086, CR10184)
IOM:	https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=331&ncdver=4&bc=AgAAQAAAAAAAAA%3d%3d&
MCD:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3162CP.pdf
	CR9861: Add ICD-10 dx codes for neoplasms of uncertain behavior effective 10/1/16: D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8, D37.01, D37.02, D37.04, D37.05, D37.09, D37.030, D37.031, D37.032, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D39.0, D39.2, D39.8, D39.11, D39.12, D40.0, D40.8, D40.11, D40.12, D41.01, D41.02, D41.11, D41.12, D41.21, D41.22, D41.3, D41.4, D41.8, D42.0, D42.1, D43.0, D43.1, D43.3, D43.4, D43.8, D44.0, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.11, D44.12, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.61, D48.62, D48.7.
	CR9861: Delete ICD-10 unspecified dx codes where laterality code is available effective 1/1/17: C00.2, C00.5, C03.9, C34.00, C34.10, C34.30, C34.80, C34.90, C40.00, C40.10, C40.20, C40.30, C40.80, C40.90, C43.20, C43.60, C43.70, C44.101, C44.111, C44.121, C44.191, C44.201, C44.211, C44.221, C44.291, C44.601, C44.611, C44.621, C44.691, C44.701, C44.711, C44.721, C44.791, C46.50, C47.10, C47.20, C49.10, C49.20, C50.019, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.919, C50.929, C56.9, C57.00, C57.10, C57.20, C62.00, C62.10, C62.90, C63.00, C63.10, C64.9, C65.9, C66.9, C69.00, C69.10, C69.20, C69.30, C69.40, C69.50, C69.60, C69.80, C69.90, C72.20, C72.30, C72.40, C74.00, C74.10, C74.90, C76.40, C76.50, C78.00, C79.00, C79.60, C79.70, D03.10, D03.20, D03.60, D03.70, C4A.10, C4A.20, C4A.60, C4A.70. **CR9861:** Remove MCS from Rule Description per MCS request. Changed RARC N345 to N386 in line 13, CARC N386 to 96 in line 17 per CORE. **CR9861:** Effective 10/1/15, add ICD-10 dx code D47.Z1 **CR9861:** Effective 1/1/17, MACs shall add 2 new PET radiopharmaceutical HCPCS codes to the existing logic and edits for this policy in accordance with the 1/1/17 Annual HCPCS Update: A9588: Fluciclovine f-18, diagnostic, 1 millicurie A9587: Gallium ga-68, dotatate, diagnostic, 0.1 millicurie **CR9861**: Effective 1/1/17, MACs shall replace deleted PET radiopharmaceutical HCPCS C9461 Choline C-11 with HCPCS A9515 Choline C-11, diagnostic, per study dose up to 20 millicuries.
	CR10086: Specify A9515 and A9588 are only approved for suspected prostate cancer recurrence, therefore, they are restricted to ICD-10 dx C61 Malignant neoplasm of prostate, Z85.46, personal history of malignant neoplasm of prostate, and modifier -PS. CMS continues to nationally non-cover initial anti-tumor treatment strategy in Medicare beneficiaries who have adenocarcinoma of the prostate. ICD-9 codes removed from spreadsheet. ICD-10 dx codes depicting in situ cancer delete 10/1/15: D03.0, D03.4, D03.8, D03.9, D03.11, D03.12, D03.21, D03.22, D03.30, D03.39, D03.51, D03.52, D03.59, D03.61, D03.62, D03.71, D03.72.