

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 3848</b>	<b>Date: August 25, 2017</b>
	<b>Change Request 10199</b>

**SUBJECT: Updates to Pub. 100-04, Chapter 18 Preventive and Screening Services and Chapter 32 Billing Requirements for Special Services and Publication 100-03, Chapter 1 Coverage Determinations Part 4**

**I. SUMMARY OF CHANGES:** This Change Request (CR) revises Pub. 100-04, chapters 18 and 32 to update claims processing instructions for smoking cessation services implemented in CR 9768 and colorectal screening services. This CR also revises Chapter 32, cardiac rehabilitation programs, to update coverage policy. These changes are intended only to clarify existing policy and no system or processing changes are anticipated.

**EFFECTIVE DATE: September 26, 2017**

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

**IMPLEMENTATION DATE: September 26, 2017**

*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.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	18/60/Colorectal Cancer Screening
R	18/60/60.1/Payment
R	18/60/60.1.1/Deductible and Coinsurance
R	18/60/60.2/HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable)
R	18/60/60.2.1/Common Working Files (CWF) Edits
R	18/60/60.6/Billing Requirements for Claims Submitted to A/B MACs (A)
R	18/60/60.7/Medicare Summary Notice (MSN) Messages
R	18/60/60.8/Remittance Advice Codes
R	18/150/Counseling to Prevent Tobacco Use
R	32/Table of Contents
R	32/12/ Counseling to Prevent Tobacco Use
R	32/12/12.1/ Counseling to Prevent Tobacco Use HCPCS and Diagnosis Coding
R	32/12/12.2/ Counseling to Prevent Tobacco Use A/B MAC (B) Billing Requirements
R	32/12/12.3/A/B MAC (A) Billing Requirements
R	32/12/12.4/Remittance Advice (RA) Notices
R	32/12/12.5/Medicare Summary Notices (MSNs)
R	32/12/12.6/ Post-Payment Review for Counseling To Prevent Tobacco Use Services
R	32/12/12.7/Common Working File (CWF) Inquiry
R	32/12/12.8/ Provider Access to Counseling To Prevent Tobacco Use Services Eligibility Data
R	32/140/140.2.2/Claims Processing Requirements for Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished On or After January 1, 2010

### **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:**

**Business Requirements  
Manual Instruction**

# Attachment - Business Requirements

Pub. 100-04	Transmittal: 3848	Date: August 25, 2017	Change Request: 10199
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**SUBJECT: Updates to Pub. 100-04, Chapter 18 Preventive and Screening Services and Chapter 32 Billing Requirements for Special Services and Publication 100-03, Chapter 1 Coverage Determinations Part 4**

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## **I. GENERAL INFORMATION**

### **A. Background: Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program**

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 established coverage provisions for cardiac rehabilitation programs and Intensive Cardiac Rehabilitation (ICR) programs. The Centers for Medicare and Medicaid Services (CMS) implemented the statutory provisions through rule making, in the Calendar Year (CY) 2010 Physician Fee Schedule (PFS) by adding section 410.49, *Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage*, to the Public Health Code of Federal Regulations (42 CFR). The cardiac rehabilitation and ICR coverage provisions included in new section 42 CF R 410.49 were effective January 1, 2010. This Change Request (CR) revises Chapter 32, cardiac rehabilitation programs, to update coverage provisions.

### **Smoking Cessation Services and Colorectal Cancer Screening Services**

This CR revises Pub. 100-04, chapters 18 and 32 to update claims processing instructions for smoking cessation services implemented in CR 9768 and changes to colorectal cancer screening services.

### **B. Policy: Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program**

The Policy statement in CR 6850, Transmittal 1974, May 21, 2010 has been updated to allow for a one-time switch from the ICR program to the cardiac rehabilitation program as set forth in the second **NOTE** below:

Effective January 1, 2010, Medicare Part B covers cardiac rehabilitation and ICR program services for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- Percutaneous transluminal coronary angioplasty or coronary stenting;
- A heart or heart-lung transplant; or,
- Other cardiac conditions as specified through a National Coverage Determination (NCD) (CR only). Effective February 18, 2014, beneficiaries with stable chronic heart failure are eligible for coverage of

cardiac rehabilitation per NCD 20.10.1. These beneficiaries are not eligible for ICR.

ICR programs must be approved by CMS through the NCD process and must meet certain criteria for approval. Individual sites wishing to provide ICR services via an approved ICR program must enroll with their local Medicare contractor or MAC as an ICR program supplier using CMS 855B. Contractors and Medicare Administrative Contractors (MACs) must ensure that claims submitted from individual ICR sites are submitted by enrolled ICR program sites.

**NOTE:** ICR programs approved through the NCD process are identified in the NCD manual under section 20.31. Approved ICR programs are also listed on our website at <https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/ICR.html>. Sites wishing to furnish ICR services via an approved ICR program may begin to enroll as ICR program suppliers using CMS 855B.

Regulations at 42 CFR 410.49 include all coverage provisions for cardiac rehabilitation and ICR items and services, identifies definitions, covered indications, settings, physician supervision requirements and physician standards, required cardiac rehabilitation and ICR components, limitations to the number of sessions covered, and the period of time over which the sessions may be covered.

Cardiac rehabilitation and ICR programs must include the following components: 1) physician-prescribed exercise each day cardiac rehabilitation and ICR items and services are furnished; 2) cardiac risk factor modification; 3) psychosocial assessment; 4) outcomes assessment; and 5) an individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed and signed by a physician every 30 days.

Cardiac rehabilitation sessions are limited to a maximum of two (2) one (1)-hour sessions per day up to 36 sessions furnished over a period of up to 36 weeks, with the option for an additional 36 sessions at Medicare contractor discretion over an extended period of time. ICR sessions are limited to 72 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

**NOTE:** A beneficiary may switch from an ICR program to a cardiac rehabilitation program. The beneficiary is limited to a one-time switch. Multiple switches are not allowable. Once the beneficiary switches from ICR to cardiac rehabilitation he or she will be limited to the number of sessions remaining in the program. For example, a beneficiary who switches from ICR to cardiac rehabilitation after 12 sessions will have 24 sessions of cardiac rehabilitation remaining, (i.e., 12 sessions of ICR + 24 sessions of cardiac rehabilitation = 36 sessions). Should a beneficiary experience more than one indication simultaneously, he or she may participate in a single series of cardiac rehabilitation or ICR sessions (i.e., a patient who had a myocardial infarction within 12 months and currently experiences stable angina is entitled to one series of cardiac rehabilitation sessions, up to 36 one (1)-hour sessions with contractor discretion for an additional 36 sessions; or one series of ICR sessions, up to 72 one (1)-hour sessions over a period up to 18 weeks). Beneficiaries may not switch from cardiac rehabilitation to ICR. Upon completion of a cardiac rehabilitation or ICR program, beneficiaries must experience another indication in order to be eligible for coverage of more cardiac rehabilitation or ICR.

Contractors shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the service that documentation is on file verifying that further treatment beyond 36 sessions of cardiac rehabilitation up to a total of 72 sessions meet the requirements of the medical policy or, for ICR, that any further sessions beyond 72 sessions within a 126 day period counting from the date of the first session or for any sessions provided after 126 days from the date of the first session meet the requirements of the medical policy. Beneficiaries who switch from ICR to cardiac rehabilitation may also be eligible for up to 72 combined sessions with contractor discretion for cardiac rehabilitation sessions after 36 (to include completed ICR sessions prior to switch). In these cases and consistent with the information above, the KX modifier must be included on the claim should the beneficiary participate in more than 36 cardiac rehabilitation sessions following the switch.

See Pub. 100-06, Medicare Financial Management Manual, chapter 6, section 420, and Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 232, and Pub. 100-08, Medicare Program Integrity Manual, chapter 15, section 15.4.2.8 for detailed information regarding cardiac rehabilitation and ICR policy and claims processing.

**Smoking Cessation Services and Colorectal Cancer Screening Services**

Updates to Pub. 100-04, chapter 18 and 32 are consistent with changes for Smoking Cessation services implemented in CR 9768 and changes to colorectal cancer screening services. These changes are intended only to clarify existing policy and no system or processing changes are anticipated.

**II. BUSINESS REQUIREMENTS TABLE**

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

Number	Requirement	Responsibility									
		A/B MAC		H H H	M A C	D M E	Shared-System Maintainers				Other
		A	B				F I S S	M C S	V M S	C W F	
10199 - 04.1	Contractors shall comply with the instructions found in the CMS Internet Only Manual (IOM) Publication 100-04, Chapter 18, Sections 18 and 32.	X	X								

**III. PROVIDER EDUCATION TABLE**

Number	Requirement	Responsibility				
		A/B MAC			D M E	C M E D I
		A	B	H H H		
	None					

**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):** William Ruiz, 410-786-9283 or [william.ruiz@cms.hhs.gov](mailto:william.ruiz@cms.hhs.gov) , Tom Dorsey, 410-786-7434 or [thomas.dorsey@cms.hhs.gov](mailto:thomas.dorsey@cms.hhs.gov)

**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: 0**

# Medicare Claims Processing Manual

## Chapter 18 - Preventive and Screening Services

### 60 - Colorectal Cancer Screening

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

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).

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

### 60.1 - Payment

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

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 *through December 31, 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.

- *For claims with dates of service on or after January 1, 2016, CPT code 81528 replaces G0464 on the CLFS.*
- Flexible sigmoidoscopy (code G0104) is paid under OPSS for hospital outpatient departments and on a reasonable cost basis for CAHs; or current payment methodologies for hospitals not subject to OPSS.
- Colonoscopies (HCPCS G0105 and G0121) and barium enemas (HCPCS G0106 and G0120) are paid under OPSS for hospital outpatient departments and on a reasonable cost basis for CAHs or current payment methodologies for hospitals not subject to OPSS. Also colonoscopies may be performed in an ASC and when done in an ASC, the ASC rate applies. The ASC rate is the same for diagnostic and screening colonoscopies. The ASC rate is paid to IHS hospitals when the service is billed on TOB 83X.

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

HCPCS Screening Code	HCPCS Diagnostic Code
G0104	45330
G0105 and G0121	45378
G0106 and G0120	74280

#### A. Special Payment Instructions for TOB 13X Maryland Waiver Hospitals

For hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission, screening colorectal services HCPCS G0104, G0105, G0106, 82270\* (G0107\*), G0120, G0121, G0328, *G0464 and 81528* are paid according to the terms of the waiver, that is 94% of submitted charges minus any unmet existing deductible, co-insurance and non-covered charges. Maryland Hospitals bill TOB 13X for outpatient colorectal cancer screenings.

#### B. Special Payment Instructions for Non-Patient Laboratory Specimen (TOB 14X) for All Hospitals

Payment for colorectal cancer screenings (CPT 82270\* (HCPCS G0107\*), HCPCS G0328, and *G0464 (Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528)* to a hospital for a non-patient laboratory specimen (TOB 14X), is the lesser of the actual charge, the fee schedule amount, or the National Limitation Amount (NLA), (including CAHs and Maryland Waiver hospitals). Part B deductible and coinsurance do not apply.

- **\*NOTE:** For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 was discontinued and replaced with CPT 82270.

### **60.1.1 – Deductible and Coinsurance**

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

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 *(Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528)*).

**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.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

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). *Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528.*

**\*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 (*Replaced with CPT 81528*) - 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 (*G0464/81528*) is covered once every 3 years for Medicare beneficiaries that meet all of the following criteria:

- Ages 50 to 85 years,
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac 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

***NOTE: Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528***

## **HCPCS G0122 - Colorectal Cancer Screening; Barium Enema**

The code is not covered by Medicare.

### **60.2.1 - Common Working Files (CWF) Edits**

***(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)***

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 CPT 81528 \*\* (HCPCS G0464\*\*)***). The CWF currently edits for valid HCPCS codes for A/B/MACs (B). (See [§60.6](#) of this chapter for TOBs.)

**\*NOTE:** For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 is discontinued and replaced with CPT 82270.

**\*\* *Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528.***

### **60.6 - Billing Requirements for Claims Submitted to A/B MACs (A)**

***(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)***

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
Barium enema	032X	G0106, G0120, G0122	12X, 13X, 22X, 23X, 85X****
Flexible Sigmoidoscopy	*	G0104	12X, 13X, 22X, 23X, 85X****
Colonoscopy-high risk	*	G0105, G0121	12X, 13X, 22X, 23X, 85X****
Multitarget sDNA - Cologuard™	030X	(G0464*****), 81528*****	13X, 14X**, 85X

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

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

\*\*\* For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, HCPCS G0107, was discontinued and replaced with CPT 82270.

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

\*\*\*\*\* *Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT 81528*

### Special Billing Instructions for Hospital Inpatients

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

### 60.7 - Medicare Summary Notice (MSN) Messages

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

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 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528*) 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 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528*) 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 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528*) 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 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528*) 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.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

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 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528*) 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](http://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 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528*) 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 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528*) 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](http://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 - Effective January 1, 2016, HCPCS G0464 has been discontinued and replaced with CPT 81528*) 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.

## **150 - Counseling to Prevent Tobacco Use**

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

*Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (Smoking*

*and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively. See Chapter 32 section 12 for coverage and billing requirements for smoking cessation services.*

***NOTE: Instructions in sections 150 thru 150.4 are no longer valid.***

Effective for claims with dates of service on and after August 25, 2010, the Centers for Medicare & Medicaid Services (CMS) will cover counseling to prevent tobacco use services for outpatient and hospitalized Medicare beneficiaries:

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.

# Medicare Claims Processing Manual

## Chapter 32 – Billing Requirements for Special Services

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### **12 - *Counseling to Prevent Tobacco Use***

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

Background: Effective for services furnished on or after March 22, 2005, a National Coverage Determination (NCD) provided for coverage of smoking and tobacco-use cessation counseling services located at Medicare National Coverage Determinations Manual, Publication 100-03 section 210.4. *CMS established a related policy entitled Counseling to Prevent Tobaccos Use at NCD Manual 210.4.1 effective August 25, 2010. However, effective September 30, 2016, the conditions of Medicare Part A and Medicare Part B coverage for smoking and tobacco-use cessation counseling services (210.4) were deleted. The remaining NCD entitled Counseling to Prevent Tobacco Use (210.4.1), remains in effect, along with HCPCS codes 99406 and 99407, specifically payable for counseling to prevent tobacco use effective October 1, 2016.*

#### **12.1 – *Counseling to Prevent Tobacco Use* HCPCS and Diagnosis Coding**

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

The following HCPCS codes should be reported when billing for *counseling to prevent* tobacco use services:

**99406** - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

**99407** - Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

Note the above codes *were effective* for dates of service on or after January 1, 2008, *and specifically effective for counseling to prevent tobacco use claims on or after October 1, 2016.*

Contractors shall allow payment for a medically necessary E/M service on the same day as the *counseling to prevent tobacco use* service when it is clinically appropriate. Physicians and qualified non-physician practitioners shall use an appropriate HCPCS code, such as HCPCS 99201– 99215, to report an E/M service with modifier 25 to indicate that the E/M service is a separately identifiable service from **99406** or **99407**.

Contractors shall only pay for 8 *counseling to prevent tobacco use* sessions in 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.

Claims for *counseling to prevent tobacco use* services shall be submitted with an appropriate diagnosis code. **NOTE:** This decision does not modify existing coverage for minimal cessation counseling (defined as 3 minutes or less in duration) which is already considered to be covered as part of each Evaluation and Management (E/M) visit and is not separately billable.

*Claims for counseling to prevent tobacco use services shall be submitted with an applicable diagnosis code:*

**ICD-9-CM** (prior to October 1, 2015)

*V15.82, personal history of tobacco use, or*

*305.1, non-dependent tobacco use disorder*

*989.84, toxic effect of tobacco*

**ICD-10-CM** (effective October 1, 2015)

*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.*

*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*

## **12.2 – Counseling to Prevent Tobacco Use A/B MAC (B) Billing Requirements**

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

A/B MACs (B) shall pay for counseling *to prevent tobacco use* services billed with codes 99406 and 99407 for dates of service on or after **October 1, 2016** A/B MACs (B) shall pay for counseling services billed with codes G0436 and G0437 for dates of service on and after August 25, 2010, through **September 30, 2016**. The type of service (TOS) for each of the new codes is 1.

A/B MACs (B) pay for these services billed based on the Medicare Physician Fee Schedule (MPFS). Deductible and coinsurance are waived. Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge, which means that charges to the beneficiary may be no more than 115% of the allowed amount.

Physicians or qualified non-physician practitioners shall bill the A/B MAC (B) for counseling to prevent tobacco use services using the ASC X12 837 professional claim format or the Form CMS-1500.

### 12.3 - A/B MAC (A) Billing Requirements

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

The A/B MACs (A) shall pay for *counseling to prevent tobacco use* services with codes 99406 and 99407 for dates of service on or after *October 1, 2016*. A/B MACs (A) shall pay for counseling services billed with codes *G0436* and *G0437* for dates of service on or after *August 25, 2010*, through *September 30, 2016*. *Deductible and coinsurance are waived.*

**A. Claims for counseling to prevent tobacco use services should be submitted using the ASC X12 837 institutional claim format or Form CMS-1450.**

The applicable bill types are 12X, 13X, 22X, 23X, 34X, 71X, 77X, 83X, and 85X. Effective *April 1, 2006*, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for *counseling to prevent tobacco use* services.

Applicable revenue codes are as follows:

Provider Type	Revenue Code
Rural Health Centers (RHCs)/Federally Qualified Health Centers (FQHCs)	052X
Indian Health Services (IHS)	0510
Critical Access Hospitals (CAHs) Method II	096X, 097X, 098X
All Other Providers	0942

**NOTE:** When these services are provided by a clinical nurse specialist in the RHC/FQHC setting, they are considered “incident to” and do not constitute a billable visit.

Payment for outpatient services is as follows:

Type of Facility	Method of Payment
Rural Health Centers (RHCs)	All-inclusive rate (AIR) for the encounter
<i>Federally Qualified Health Centers (FQHCs)</i>	<i>FQHC Prospective Payment System (PPS) for the encounter</i>
Indian Health Service (IHS)/Tribally owned or operated hospitals and hospital- based facilities	<i>AIR</i>
IHS/Tribally owned or operated non-hospital-based facilities	Medicare Physician Fee Schedule (MPFS)
IHS/Tribally owned or operated Critical Access Hospitals (CAHs)	Facility Specific Visit Rate
Hospitals subject to the Outpatient Prospective Payment System (OPPS)	Ambulatory Payment Classification (APC)
Hospitals not subject to OPPS	Payment is made under current methodologies

Skilled Nursing Facilities (SNFs)	<i>MPFS</i>
<b>NOTE:</b> Included in Part A PPS for skilled patients.	
Home Health Agencies (HHAs)	<i>MPFS</i>
Critical Access Hospitals (CAHs)	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 <i>MPFS</i> Data Base
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.

**NOTE:** Inpatient claims submitted with *counseling to prevent tobacco use services* are processed under the current payment methodologies. *In addition, payment is not allowed for inpatients whose primary diagnosis is counseling to prevent tobacco use.*

## 12.4 - Remittance Advice (RA) Notices

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

Contractors shall use the appropriate claim RA(s) when denying payment for counseling *to prevent tobacco use* services.

The following messages are used where applicable:

- If the counseling services were furnished before *August 25, 2010*, use an appropriate RA claim adjustment reason code (*CARC*), such as, 26, “Expenses incurred prior to coverage.”
- If the claim for counseling services is being denied because the coverage criteria are not met, use an appropriate *CARC*, such as, *272, Coverage/program guidelines were not met.*
- If the claim for counseling services is being denied because the maximum benefit has been reached, use an appropriate *CARC*, such as, 119, “Benefit maximum for this time period or occurrence has been reached.”

## 12.5 - Medicare Summary Notices (MSNs)

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

(When denying claims for counseling *to prevent tobacco use* services that were performed prior to the effective date of coverage, contractors shall use an appropriate MSN, such as, MSN 21.11, “This service was not covered by Medicare at the time you received it.”

When denying claims for counseling services on the basis that the coverage criteria were not met, use an appropriate MSN, such as MSN 21.21, “This service was denied because Medicare only covers this service under certain circumstances.”

When denying claims for counseling services that have dates of service exceeding the maximum benefit allowed, use an appropriate MSN, such as MSN 17.8, “*Payment is denied because the maximum benefit allowance has been reached.*”

## 12.6 - Post-Payment Review for Counseling *To Prevent Tobacco Use* Services

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

As with any claim, Medicare may decide to conduct post-payment reviews to determine that the services provided are consistent with coverage instructions. Providers must keep patient record information on file for each Medicare patient for whom a *counseling* claim is made. These medical records can be used in any post-payment reviews and must include standard information along with sufficient patient histories to allow determination that the steps required in the coverage instructions were followed.

## **12.7 - Common Working File (CWF) Inquiry**

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

The Common Working File (CWF) maintains the number of counseling sessions rendered to a beneficiary. 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.

## **12.8 - Provider Access to Counseling *To Prevent Tobacco Use* Services Eligibility Data**

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

Providers may access coverage period remaining counseling sessions and a next eligible date, when there are no remaining sessions, through the 270/271 eligibility inquiry and response transaction.

## **140.2.2 – Claims Processing Requirements for Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished On or After January 1, 2010**

*(Rev.3848, Issued: 08- 25-17, Effective: 09-26-17, Implementation: 09- 26-17)*

***NOTE:** A beneficiary may switch from an ICR program to a CR program. The beneficiary is limited to a one-time switch, multiple switches are not allowable. Once the beneficiary switches from ICR to CR he or she will be limited to the number of sessions remaining in the program. For example, a beneficiary who switches from ICR to CR after 12 sessions will have 24 sessions of CR remaining, (i.e., 12 sessions of ICR + 24 sessions of CR = total of 36 sessions). Should a beneficiary experience more than one indication simultaneously, he or she may participate in a single series of CR or ICR sessions (i.e., a patient who had a myocardial infarction within 12 months and currently experiences stable angina is entitled to one series of CR sessions, up to 36 1-hour sessions with contractor discretion for an additional 36 sessions; or one series of ICR sessions, up to 72 1-hour sessions over a period up to 18 weeks). Beneficiaries may not switch from CR to ICR. Upon completion of a CR or ICR program, beneficiaries must experience another indication in order to be eligible for coverage of more CR or ICR.*

*Contractors shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the service that documentation is on file verifying that further treatment beyond 36 sessions of CR up to a total of 72 sessions meets the requirements of the medical policy or, for ICR, that any further sessions beyond 72 sessions within a 126 day period counting from the date of the first session or for any sessions provided after 126 days from the date of the first session meet the requirements of the medical policy. Beneficiaries who switch from ICR to CR may also be eligible for up to 72 combined sessions with contractor discretion for CR sessions after 36 (to include completed ICR sessions prior to switch). In these cases and consistent with the information above, the KX modifier must be included on the claim should the beneficiary participate in more than 36 CR sessions following the switch.*

*See Pub. 100-06, Medicare Financial Management Manual, chapter 6, section 420, and Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 232, and Pub. 100-08, Medicare Program Integrity Manual, chapter 15, section 15.4.2.8 for detailed information regarding CR and ICR policy and claims processing.*