CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3402	**Date: November 6, 2015**
	Change Request 9250

NOTE: This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet.

Transmittal 3299, dated August 6, 2015, is being rescinded and replaced by Transmittal 3402, dated November 6, 2015, to remove MCS from requirement 9250.5 and because the CR is no longer "sensitive/controversial." All other information remains the same.

SUBJECT: Payment Reduction for Computed Tomography (CT) Diagnostic Imaging Services

I. SUMMARY OF CHANGES: Effective January 1, 2016, a payment reduction of 5 percent applies to Computed Tomography (CT) services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. The payment reduction increases to 15 percent in 2017 and subsequent years.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2016

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
R	12/TOC
N	12/20.4.7 - Services That Do Not Meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013

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: 3402	Date: November 6, 2015	Change Request: 9250

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SUBJECT: Payment Reduction for Computed Tomography (CT) Diagnostic Imaging Services

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2016

I. GENERAL INFORMATION

A. Background: Section 218(a) of the Protecting Access to Medicare Act of 2014 (PAMA) is titled "Quality Incentives To Promote Patient Safety and Public Health in Computed Tomography Diagnostic Imaging." It amends the Social Security Act (SSA) by reducing payment for the technical component (and the technical component of the global fee) of the Physician Fee Schedule service (5 percent in 2016 and 15 percent in 2017 and subsequent years) for computed tomography (CT) services identified by CPT codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74178, 74261-74263, and 75571-75574 furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, entitled "Standard Attributes on CT Equipment Related to Dose Optimization and Management."

The statutory provision requires that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable CT service was furnished that was not consistent with the NEMA CT equipment standard, and that such information may be included on a claim and may be a modifier. The statutory provision also provides that such information shall be verified, as appropriate, as part of the periodic accreditation of suppliers under SSA section 1834(e) and hospitals under SSA section 1865(a). Any reduced expenditures resulting from this provision are not budget neutral.

To implement this provision, the Centers for Medicare and Medicaid Services (CMS) will create modifier "CT" (Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard). Beginning in 2016, claims for CT scans described by above-listed CPT codes (and any successor codes) that are furnished on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier "CT" that will result in the applicable payment reduction.

B. Policy: Beginning January 1, 2016, a payment reduction of 5 percent applies to the technical component (and the technical component of the global fee) for Computed Tomography (CT) services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. This payment reduction becomes 15 percent for 2017 and succeeding years.

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	
9250.1	Contactors shall accept new modifier CT (Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard) in their systems. (NOTE: The CT modifier will be included in the 2016 HCPCS update.)		X		X					
9250.2	Effective for claims with dates of service January 1, 2016, through December 31, 2016, a 5 percent reduction applies to the technical component (and the technical component of the global fee) of the MPFS amount when the CT modifier is billed with the procedure codes in requirement 4. Contractors shall apply the CT modifier reduction immediately following the application of the OPPS cap to the MPFSDB. (The MPFSDB amount cannot be greater than the OPPS amount. Contractors compare the OPPS Facility and Non-Facility Payment fields to the MPFSDB Facility and Non-Facility amounts and use the lower amount.) <u>The CT modifier will reduce whichever of these two amounts applies.</u>		X				X			
9250.2.1	For a global procedure billed with modifier CT, contractors shall reduce the global fee schedule amount by an amount equal to 5 percent of the fee schedule amount for the TC only code.		X				X			
9250.2.2	For codes billed with both modifier TC and CT, contractors shall reduce the fee schedule amount by 5 percent.		X				X			
9250.3	Effective for claims with dates of service on or after January 1, 2017, a 15 percent reduction applies to the technical component (and the technical component of the global fee) of the MPFS amount when the CT modifier is billed with the procedure codes in requirement 4. Contractors shall apply the CT modifier reduction immediately following the application of the OPPS cap to the MPFSDB. (The MPFSDB amount cannot be greater than the OPPS amount. Contractors compare the OPPS Facility and Non-Facility Payment fields to the MPFSDB Facility and Non-Facility amounts and use the lower amount.) <u>The CT modifier will reduce whichever of these two amounts applies.</u>		X				X			
9250.3.1	For a global procedure billed with modifier CT, contractors shall reduce the global fee schedule		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	amount by an amount equal to 15 percent of the fee schedule amount for the TC only code.									
9250.3.2	For codes billed with both modifier TC and CT, contractors shall reduce the fee schedule amount by 15 percent.		X				X			
9250.4	Contractors shall apply the CT modifier reduction as described in requirements 2 and 3 to the following codes: 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74178, 74261-74263, and 75571-75574		X							
9250.4.1	Each year, CMS will maintain a list of codes subject to the CT modifier in the web supporting files for the annual rule. Contractors shall use this list to identify the global and technical only codes which may have the CT modifier applied.		X							
9250.5	Contractors shall note that the beneficiary is not liable for the CT modifier payment reduction.		X							
9250.6	Beginning January 1, 2016 for claims in which the CT modifier reduction has been applied, the contractors shall use the following messages: Medicare Summary Notice (MSN) 30.1 – The approved amount is based on a special payment method. Spanish Language Translation: La cantidad aprobada está basada en un método especial de pago. Claim Adjustment Reason Code 237 – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Remittance Advice Remark Code N759 – Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group Code: CO (contractual obligation)									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9250.7	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			

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): Ian Kramer, 410-786-5777 or ian.kramer@cms.hhs.gov (Claims processing contact) , Roberta Epps, 410-786-4503 or roberta.epps@cms.hhs.gov (Payment Policy contact)

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 12 - Physicians/Nonphysician Practitioners

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(Rev.3402, Issue:11-06-15)

20.4.7 – Services That Do Not Meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013

(Rev.3402, Issued: 11-06-15, Effective: 01-01-16, Implementation: 01-04-16)

Section 218(a) of the Protecting Access to Medicare Act of 2014 (PAMA) is titled "Quality Incentives To Promote Patient Safety and Public Health in Computed Tomography Diagnostic Imaging." It amends the Social Security Act (SSA) by reducing payment for the technical component (and the technical component of the global fee) of the Physician Fee Schedule service (5 percent in 2016 and 15 percent in 2017 and subsequent years) for computed tomography (CT) services identified by CPT codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74178, 74261-74263, and 75571-75574 furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, entitled "Standard Attributes on CT Equipment Related to Dose Optimization and Management."

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Beginning in 2016, claims for CT scans described by above-listed CPT codes (and any successor codes) that are furnished on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier "CT" that will result in the applicable payment reduction.

A list of codes subject to the CT modifier will be maintained in the web supporting files for the annual rule.

Beginning January 1, 2016, a payment reduction of 5 percent applies to the technical component (and the technical component of the global fee) for Computed Tomography (CT) services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. This payment reduction becomes 15 percent beginning January 1, 2017, and after.