CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3329	**Date: August 14, 2015**
	Change Request 8628

SUBJECT: Update to Pub. 100-04, Chapter 18 to Provide Language-Only Changes for Updating ICD-10, the 02/12 version of the Form CMS-1500, and ASC X12

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ICD-10, the 02/12 version of the Form CMS-1500, and ASC X12 language in Pub 100-04, Chapter 18. Also, references to MACs replace the references to old contractor types in the sections that are included in this CR. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: Upon implementation of ICD-10; ASC X12: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: ASC X12: September 14, 2015; Upon implementation of ICD-10

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/Table of Contents
R	18/10.2.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes
R	18/10.3.1/Roster Claims Submitted to A/B MACs (B) for Mass Immunization
R	18/10.3.1.1/Centralized Billing for Influenza Virus and Pneumococcal Vaccines to Medicare A/B MACs (B)
R	18/10.3.2/Claims Submitted to A/B MACs (A) for Mass Immunizations of Influenza Virus and Pneumococcal Vaccinations
R	18/20.2/HCPCS and Diagnosis Codes for Mammography Services
R	18/20.5 Billing Requirements – A/B MAC (B) Claims
R	18/20.8.2/Remittance Advice Messages
R	18/30.2/Pap Smears On and After July 1, 2001
R	18/30.5/HCPCS Codes for Billing

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/30.6/Diagnoses Codes
R	18/30.9/Remittance Advice Codes
R	18/40.2/Screening Pelvic Examinations on and After July 1, 2001
R	18/40.4/Diagnoses Codes
R	18/40.6/Revenue Code and HCPCS Codes for Billing
R	18/40.8/Remittance Advice Codes
R	18/50.5/Diagnosis Coding
R	18/50.8/Remittance Advice Notices
R	18/60.1/Payment
R	18/60.3/Determining High Risk for Developing Colorectal Cancer
R	18/60.6/Billing Requirements for Claims Submitted to A/B MACs (A)
R	18/60.8/Remittance Advice Notices
R	18/70.1/Claims Submission Requirements and Applicable HCPCS Codes
R	18/70.1.1/HCPCS and Diagnosis Coding
R	18/70.4/Remittance Advice Notices
R	18/80.2/A/B Medicare Administrative Contractor (MAC) (B) and Contractor Billing Requirements
R	18/90.2/A/B MAC (B) Billing Requirements
R	18/90.2.1/Modifier Requirements for Pre-diabetes
R	18/90.3/A/B MAC (A) Billing Requirements
R	18//90.3.1/Modifier Requirements for Pre-diabetes
R	18//90.4/Diagnosis Code Reporting
R	18/90.5/Medicare Summary Notices
R	18/100.2/A/B MAC (B) Billing Requirements
R	18/100.3/A/B MAC (A) Billing Requirements
R	18/100.4/Diagnosis Code Reporting
R	18/100.5/Medicare Summary Notice
R	18/130.2/Billing Requirements
R	18/130.5/Diagnosis Code Reporting
R	18/130.6/Medicare Summary Notice (MSN) and Claim Adjustment Reason Codes (CARCs)
R	18/140.7/Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claims Adjustment Reason Codes (CARCs), and Advance Beneficiary Notices (ABNs)
R	18/150.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Coding

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/150.3/Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claims Adjustment Reason Codes (CARCs), and Group Codes
R	18/170.2/Diagnosis Code Reporting
R	19/170.3/Billing Requirements
R	18/200.1/Policy
R	18/200.3/Professional Billing Requirements
R	18/200.4/Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
R	18/200.5/Common Working File (CWF) Edits

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: 3329**	**Date: August 14, 2015**	**Change Request: 8628**

SUBJECT: Update to Pub. 100-04, Chapter 18 to Provide Language-Only Changes for Updating ICD-10, the 02/12 version of the Form CMS-1500, and ASC X12

EFFECTIVE DATE: Upon implementation of ICD-10; ASC X12: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: ASC X12: September 14, 2015; Upon implementation of ICD-10

I. GENERAL INFORMATION

A. Background: This Change Request (CR) contains language-only changes for updating ICD-10, the 02/12 version of the Form CMS-1500, and ASC X12 language in Pub 100-04, Chapter 18. Also, references to MACs replace the references to old contractor types in the sections that are included in this CR. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

B. Policy: This Change Request (CR) contains language-only changes for updating ICD-10, the 02/12 version of the Form CMS-1500, and ASC X12 language in Pub. 100-04, Chapter 18. Also, references to MACs replace the references to old contractor types in the sections that are included in this CR. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

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	
8628.1	A/B MACs and the SMAC shall be aware of the updated language for ICD-10, the 02/12 version of the Form CMS-1500, and for ASC X12 in Pub. 100 - 04, Chapter 18.	X	X	X						RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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): Not Applicable

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

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10.3.2 - Claims Submitted to *A/B MACs (A)* for Mass Immunizations of Influenza Virus and Pneumococcal Vaccinations

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

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80.2 - A/B Medicare Administrative Contractor (MAC) *(B)* Billing Requirements

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100.2 - *A/B MAC (B)* Billing Requirements

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

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

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

HCPCS	Definition
90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use
90654	Influenza virus vaccine, split virus, preservative-free, for intradermal use, for adults ages 18 - 64;
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use;
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use;
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use;
90660	Influenza virus vaccine, live, for intranasal use;
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90672	Influenza virus vaccine, live, quadrivalent, for intranasal use
90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use;
90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use

HCPCS	Definition
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use;
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use;
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use;
90746	Hepatitis B vaccine, adult dosage, for intramuscular use; and
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.

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

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

*** NOTE:** For claims with dates of service prior to January 1, 2006, OPPS and non-OPPS hospitals report G0010 for hepatitis B vaccine administration. For claims with dates of service January 1, 2006 until December 31, 2010, OPPS hospitals report 90471 or 90472 for hepatitis B vaccine administration as appropriate in place of G0010. Beginning January 1, 2011, providers should report G0010 for billing under the OPPS rather than 90471 or 90472 to ensure correct waiver of coinsurance and deductible for the administration of hepatitis B vaccine.

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

ICD-9-CM **Diagnosis Code**	**Description**
V03.82	Pneumococcus
V04.81**	Influenza
V06.6***	Pneumococcus and Influenza
V05.3	Hepatitis B

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

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

***NOTE**: ICD-10-CM diagnosis code Z23 may be used for an encounter for immunizations effective with the implementation of ICD-10.*

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

If the diagnosis code and the narrative description are correct, but the HCPCS code is incorrect, the *A/B MAC (A or B)* may correct the HCPCS code and pay the claim. For example, if the reported diagnosis code is V04.81 and the narrative description (if annotated on the claim) says "flu shot" but the HCPCS code is incorrect, contractors may change the HCPCS code and pay for the flu vaccine. Effective October 1, 2006, A/B MACs *(B)* should follow the instructions in Pub. 100-04, Chapter 1, Section 80.3.2.1.1 (*A/B MAC (B)* Data Element Requirements) for claims submitted without a HCPCS code.

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

- UPIN code SLF000 to be reported on claims submitted prior to May 23, 2008, when Medicare began accepting NPIs, only

- The provider's own NPI to be reported in the NPI field for the attending physician on claims submitted on or after May 23, 2008, when NPI requirements were implemented.

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

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

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

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

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

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

Contractors must provide Palmetto-Railroad Retirement Board (RRB) with local pricing files for pneumococcal and influenza virus vaccine and their administration. If PHCs or other individuals or entities inappropriately bill pneumococcal or influenza virus vaccinations using the roster billing method, contractors return the claim to the provider with a cover letter explaining why it is being returned and the criteria for the roster billing process. Contractors may not deny these claims.

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

A. Modified Form CMS-1500 for Cover Document

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

Item #	*Instruction*
Item 1:	An X in the Medicare block
Item 2:	(Patient's Name): "SEE ATTACHED ROSTER"
Item 11:	(Insured's Policy Group or FECA Number): "NONE"
Item 20:	(Outside Lab?): An "X" in the NO block
Item 21:	(Diagnosis or Nature of Illness): Line A: Choose appropriate diagnosis code from §10.2.1 *ICD Ind. Block: Enter 9 if ICD-9-CM or 0 if ICD-10-CM is applicable.* *Enter the indicator as a single digit between the vertical dotted lines.*
Item 24B:	(Place of Service (POS)): Line 1: "60" Line 2: "60" NOTE: POS Code "60" must be used for roster billing.
Item 24D:	(Procedures, Services or Supplies): Line 1: Pneumococcal vaccine: "90732" or Influenza Virus vaccine: "Select appropriate influenza virus vaccine code" Line 2: Pneumococcal vaccine Administration: "G0009" or Influenza Virus Vaccine Administration: "G0008"
Item 24E:	(Diagnosis *Pointer*): Lines 1 and 2: "*A*"
Item 24F:	($ Charges): The entity must enter the charge for each listed service. If the entity is not charging for the vaccine or its administration, it should enter 0.00 or "NC" (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC pneumococcal or influenza virus vaccine claims only if your system is able to accept them.
Item 27:	(Accept Assignment): An "X" in the YES block.
Item 29:	(Amount Paid): "$0.00"
Item 31:	(Signature of Physician or Supplier): The entity's representative must sign the modified Form CMS-1500.

Item #	*Instruction*
Item 32:	Enter the name, address, and ZIP code of the location where the service was provided (including centralized billers).
Item32a:	Enter the NPI of the service facility.
Item 33:	(Physician's, Supplier's Billing Name): The entity must complete this item to include the Provider Identification Number (not the Unique Physician Identification Number) or NPI when required.
Item 33a:	Effective May 23, 2007, and later, enter the NPI of the billing provider or group.

B. Format of Roster Claims

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

The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;

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

- Control number for contractor;
- Patient's health insurance claim number;
- Patient's name;
- Patient's address;
- Date of birth;
- Patient's sex; and
- Beneficiary's signature or stamped "signature on file".

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

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

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

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

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

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

The CMS currently authorizes a limited number of providers to centrally bill for influenza virus and pneumococcal immunization claims. Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type "Mass Immunization Roster Biller," as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

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

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

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

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

A. Processing Contractor

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

B. Request for Approval

Approval to participate in the CMS centralized billing program is a two part approval process. Individuals and corporations who wish to enroll as a CMS mass immunizer centralized biller must send their request in writing. CMS will complete Part 1 of the approval process by reviewing preliminary demographic information included in the request for participation letter. Completion of Part 1 is not approval to set up vaccination clinics, vaccinate beneficiaries, and bill Medicare for reimbursement. All new participants must complete Part 2 of the approval process (Form CMS-855 Application) before they may set up vaccination clinics, vaccinate Medicare

beneficiaries, and bill Medicare for reimbursement. If an individual or entity's request is approved for centralized billing, the approval is limited to 12 months from September to August 31 of the next year. It is the responsibility of the centralized biller to reapply for approval each year. The designated contractor shall provide in writing to CMS and approved centralized billers notification of completion and approval of Part 2 of the approval process. The designated contractor may not process claims for any centralized biller who has not completed Parts 1 and 2 of the approval process. If claims are submitted by a provider who has not received approval of Parts 1 and 2 of the approval process to participate as a centralized biller, the contractor must return the claims to the provider to submit to the A/B MAC *(B)* for payment.

C. Notification of Provider Participation to the Processing Contractor

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

D. Enrollment

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

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

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

E. Electronic Submission of Claims on Roster Bills

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

F. Required Information on Roster Bills for Centralized Billing

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

G. Payment Rates and Mandatory Assignment

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

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

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

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

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

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

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

H. Common Working File Information

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

I. Provider Education Instructions for the Processing Contractor

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

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

By April 1 of every year, all A/B MACs *(B)* must publish in their bulletins and put on their Web sites the following notification to providers. Questions from interested providers should be forwarded to the central office address below. A/B MACs *(B)* must enter the name of the assigned processing contractor where noted before sending.

NOTIFICATION TO PROVIDERS

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

Individuals and entities interested in centralized billing must contact CMS central office, in writing, at the following address by June 1 of the year they wish to begin centrally billing.

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

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

CRITERIA FOR CENTRALIZED BILLING

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

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

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

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

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

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

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

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

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

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

- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. [Fill in name of contractor] can provide this information.

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

- If an individual or entity's request for centralized billing is approved, the approval is limited to the 12 month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. Claims will not be processed for any centralized biller without permission from CMS.

- Each year the centralized biller must contact [Fill in name of contractor] to verify understanding of the coverage policy for the administration of the pneumococcal vaccine, and for a copy of the warning language that is required on the roster bill.

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

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

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

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

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

    4. A list of the states in which influenza virus and pneumococcal clinics will be held;

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

    6. Whether the nurses who will administer the influenza virus and pneumococcal vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza virus and pneumococcal vaccinations;

    7. Names and addresses of all entities operating under the corporation's application;

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

10.3.2 - Claims Submitted to A/B MACs *(A)* for Mass Immunizations of Influenza Virus and Pneumococcal Vaccinations

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

Some potential "mass immunizers," such as hospital outpatient departments and HHAs, have expressed concern about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to increase the number of beneficiaries who obtain needed preventive immunizations, simplified (roster) billing procedures are available to mass immunizers. The simplified (roster) claims filing procedure has been expanded for the pneumococcal vaccine. A mass immunizer is defined as any entity that gives the influenza virus vaccine or pneumococcal vaccine to a group of beneficiaries, e.g., at public health clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date are required. (See §10.3.2.2 for an exception to this requirement for inpatient hospitals.)

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

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

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

The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;
- Patient health insurance claim number; and
- Beneficiary signature or stamped "signature on file."

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

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

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

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

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

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

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

- The words "See Attached Roster" (Patient Name);
- Patient Status code 01 (Patient Status);

- Condition code M1 (Condition Code) (See NOTE below);
- Condition code A6 (Condition Code);
- Revenue code 636 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- Revenue code 771 (Revenue Code), along with the appropriate "G" HCPCS code (HCPCS Code);
- "Medicare" (Payer, line A);
- The words "See Attached Roster" (Provider Number, line A); and
- Diagnosis code
    - ***ICD-9-CM*** - V03.82 for the pneumococcal vaccine or V04.8 for Influenza Virus vaccine (Principal Diagnosis Code). For influenza virus vaccine claims with dates of service October 1, 2003 and later, use diagnosis code V04.81.
    - ***ICD-10-CM*** *- Use Z23 for an encounter for immunization effective with the implementation of ICD-10.*
- Influenza virus vaccines require:
    - the UPIN SLF000 on claims submitted before May 23, 2007, or
    - the provider's own NPI to be reported in the NPI field for the attending physician on claims submitted on or after May 23, 2007.

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

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

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

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

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

20.2 - HCPCS and Diagnosis Codes for Mammography Services

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

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

HCPCS Code	Definition
77051* (76082*)	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography (list separately in addition to code for primary procedure). **Code 76082 is effective January 1, 2004 thru December 31, 2006. Code 77051 is effective January 1, 2007.**
77052* (76083*)	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography (list separately in addition to code for primary procedure). **Code 76083 is effective January 1, 2004 thru December 31, 2006. Code 77052 is effective January 1, 2007.**
77055* (76090*)	Diagnostic mammography, unilateral.
77056* (76091*)	Diagnostic mammography, bilateral.
77057* (76092*)	Screening mammography, bilateral (two view film study of each breast).
77063**	Screening Breast Tomosynthesis; bilateral (list separately in addition to code for primary procedure).
G0202	Screening mammography, producing direct 2-D digital image, bilateral, all views. **Code is effective April 1, 2001. This code descriptor effective January 1, 2015.**
G0204	Diagnostic mammography, direct 2-D digital image, bilateral, all views. **Code is effective April 1, 2001. This code descriptor is effective January 1, 2015.**
G0206	Diagnostic mammography, producing direct 2-D digital image, unilateral, all views**. Code is effective April 1, 2001. This code descriptor is effective January 1, 2015.**
G0279**	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206)

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

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

New Modifier "-GG": Performance and payment of a screening mammography and diagnostic mammography on same patient same day - This is billed with the Diagnostic Mammography code to show the test changed from a screening test to a diagnostic test. Contractors will pay both the screening and

diagnostic mammography tests. This modifier is for tracking purposes only. This applies to claims with dates of service on or after January 1, 2002.

A. Diagnosis for Services On or After January 1, 1998

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

ICD-9-CM

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

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

ICD-10-CM

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

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

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

In addition, for institutional claims, providers report diagnosis code V76.11 or V76.12 *(ICD-9-CM) or Z12.31 (if ICD-10-CM is applicable)* in "Principal Diagnosis Code" if the screening mammography is the only service reported on the claim. If the claim contains other services in addition to the screening mammography, *these* diagnostic codes V76.11 or V76.12 *(ICD-9-CM) or Z12.31 (ICD-10-CM)* are reported, as appropriate, in "Other Diagnostic Codes." **NOTE:** Information regarding the form locator number that corresponds to the principal and other diagnosis codes is found in chapter 25.

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

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

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

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

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

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

- V10.3 "Personal history - Malignant neoplasm female breast";
- V16.3 "Family history - Malignant neoplasm breast"; or

- V15.89 "Other specified personal history representing hazards to health."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A/B MAC (B) **Provider Education**

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

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

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

20.8.2 - Remittance Advice Messages

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

If the claim is denied because the beneficiary is under 35 years of age, contractors must use existing ASC X12 835 claim adjustment reason code/message 6, "The procedure/revenue code is inconsistent with the patient's age" along with remark code M37 (at the line item level), "Service is not covered when the patient is under age 35."

If the claim is denied for a woman 35-39 because she has previously received this examination, contractors must use existing ASC X12 835 claim adjustment reason code/message 119, "Benefit maximum for this time period or occurrence has been reached" along with the remark code M89 (at the line item level), "Not covered more than once under age 40."

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, contractors must use existing ASC X12 835 claim adjustment reason code/message

119, "Benefit maximum for this time period or occurrence has been reached" along with remark code M90 (at the line item level), "Not covered more than once in a 12-month period."

For *A/B MACs (A)* only:

If the claim is denied because the provider that performed the screening is not certified to perform the type of mammography billed (film and/or digital) use existing ASC X12 835 claim adjustment reason code/message B7, "This provider was not certified/eligible to be paid for this procedure/service on this date of service".

For *A/B* MACs *(B)* only:

For claims submitted by a facility not certified to perform film mammography, use existing reason code 171, "Payment is denied when performed/billed by this type of provider in this type of facility." along with remark code N110, "This facility is not certified for film mammography."

For claims submitted by a facility not certified to perform digital mammograms, use existing reason code 171, "This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty" along with remark code N92, "This facility is not certified for digital mammography."

For claims that were submitted without the facility's FDA-assigned certification number, use existing reason code 16, "Claim/service lacks information which is needed for adjudication" along with remark code MA128 "Missing/incomplete/invalid FDA approval number."

For claims that were submitted with an invalid facility certification number, use existing reason code 125, "Payment adjusted due to a submission/billing error(s) along with remark code MA128 "Missing/incomplete/invalid FDA approval number."

30.2 - Pap Smears On and After July 1, 2001

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

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

30.5 - HCPCS Codes for Billing

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

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

A. Codes Billed to the *A/B MAC (B)* and Paid Under the Physician Fee Schedule

The following HCPCS codes are submitted by those providers/entities that submit claims to *A/B MACs (B).*

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

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

- P3001 - Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by a physician;
- G0124 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician; and
- G0141 - Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual re-screening, requiring interpretation by physician.

B. Codes Paid Under the Clinical Lab Fee Schedule by *A/B MACs (A) and (B)*

The following codes are billed to *A/B MACs (A)* by providers they serve, or billed to *A/B MACs (B)* by the physicians/suppliers they service.

- P3000 - Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision;
- G0123 - Screening cytopathology, cervical or vaginal (any reporting system) collected in preservative fluid; automated thin layer preparation, screening by cytotechnologist under physician supervision;
- G0143 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and re-screening, by cytotechnologist under physician supervision;
- G0144 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system under physician supervision;
- G0145 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual re-screening under physician supervision;
- G0147 - Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision; and
- G0148 - Screening cytopathology smears, cervical or vaginal, performed by automated system with manual reevaluation.

C. Payment of Q0091 When Billed to *A/B MACs (A)*

Payment for code Q0091 in a hospital outpatient department is under OPPS. A SNF is paid using the technical component of the MPFS. For a CAH, payment is on a reasonable cost basis. *For information on payment policies and billing in RHCs and FQHC, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 13, §210 and Pub. 100-04, Medicare Claims Processing Manual, chapter 9, §120.*

The technical component of a screening Pap smear is outside the RHC/FQHC benefit. If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the *A/B MAC (A)* under the bill type 13X, 14X, 22X, 23X, or 85X as appropriate using their base provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). For independent RHCs/FQHCs, the practitioner bills the technical component to the *A/B MAC (B)*

using the ASC X12 837 professional claim format or on Form CMS-1500. Effective April 1, 2006, type of bill 14X is for non-patient laboratory specimens.

D. Payment of Q0091 When Billed to *A/B MACs (B)*

HCPCS code Q0091 is paid under the Medicare physician fee schedule.

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

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

E. Common Working File (CWF) Editing for Q0091

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

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

30.6 - Diagnoses Codes

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

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

High Risk Diagnosis Codes

ICD-9-CM codes	***Description***	***ICD-10-CM codes***	***Description***
V15.89	*Other specified personal history presenting hazards to health*	*Z77.22*	*Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)*
V15.89	*Other specified personal history presenting hazards to health*	*Z77.9*	*Other contact with and (suspected) exposures hazardous to health*
V15.89	*Other specified personal history presenting hazards to health*	*Z91.89*	*Other specified personal risk factors, not otherwise classified*

ICD-9-CM codes	*Description*	*ICD-10-CM codes*	*Description*
V15.89	*Other specified personal history presenting hazards to health*	*Z92.89*	*Personal history of other medical treatment*
V69.2	*High-risk sexual behavior*	*Z72.51*	*High-risk heterosexual behavior*
V69.2	*High-risk sexual behavior*	*Z72.52*	*High-risk homosexual behavior*
V69.2	*High-risk sexual behavior*	*Z72.53*	*High-risk bisexual behavior*

For High risk patients a pap smear may be paid annually.

Low Risk Diagnosis Codes

ICD-9-CM codes	*Description*	*ICD-10-CM codes*	*Description*
V72.31	*Routine gynecological examination*	*Z01.411*	*Encounter for gynecological examination (general) (routine) with abnormal findings*
V72.31	*Routine gynecological examination*	*Z01.419*	*Encounter for gynecological examination (general) (routine) without abnormal findings*
V76.2	*Screening for malignant neoplasms of the cervix*	*Z12.4*	*Encounter for screening for malignant neoplasm of cervix*
V76.47	*Special screening for malignant neoplasms, vagina*	*Z12.72*	*Encounter for screening for malignant neoplasm of vagina*
V76.49	*Special screening for malignant neoplasms, other sites*	*Z12.79*	*Encounter for screening for malignant neoplasm of other genitourinary organs*
V76.49	*Special screening for malignant neoplasms, other sites*	*Z12.89*	*Encounter for screening for malignant neoplasm of other sites*

For Low risk patients a pap smear may be paid every 2 years.

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

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

There are a number of appropriate diagnosis codes that can be used in billing for screening Pap smear services that the provider can list on the claim to give a true picture of the patient's condition. In addition, one of the *diagnoses listed in either the high risk or low risk tables above (§30.6) must be on the claim* to indicate either low risk or high risk depending on the patient's condition, *and the screening Pap smear service must point to this diagnosis code*. Providers must make sure that for screening Pap smears for a high risk beneficiary *a* high risk diagnosis code appears *on the claim and that the screening Pap smear service points to this diagnosis code.* If Pap smear claims do not point to one of these specific diagnoses the claim will reject in the CWF. **Periodically, *A/B MACs (B)* should do provider education on diagnosis coding of Pap smear claims.**

If these pointers are not present on claims submitted to *A/B MACs (B)*, CWF will reject the record.

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

Providers report one of the *above* diagnosis codes *using the institutional claim.* Information regarding the form locator numbers that correspond to the diagnosis codes *for the Form* CMS-1450 is found in chapter 25.):

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

30.9 - Remittance Advice Codes

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

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

- Claim adjustment reason code 119 - "Benefit maximum for this time period has been reached" at the line level, and
- Remark code M83 - "Service is not covered unless the patient is classified as at high risk" at the line item level.

40.2 - Screening Pelvic Examinations on and After July 1, 2001

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

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

40.4 - Diagnoses Codes

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

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

Low Risk Diagnosis Codes

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

ICD-9-CM codes	*Description*	*ICD-10-CM codes*	*Description*
V76.49	*Special screening for malignant neoplasms, other sites-* ***NOTE:*** *Providers use this diagnosis for women without a cervix.*	*Z12.89*	*Encounter for screening for malignant neoplasm of other sites*

High Risk Diagnosis Codes

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

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

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

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

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

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

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

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

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

40.6 - Revenue Code and HCPCS Codes for Billing

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

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

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

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

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

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

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

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

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

40.8 - Remittance Advice Codes

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

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

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

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

50.5 - Diagnosis Coding

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

Prostate cancer screening digital rectal examinations and screening Prostate Specific Antigen (PSA) blood tests must be billed using *either* screening ("V") code V76.44 (Special Screening for Malignant Neoplasms, Prostate *if ICD-9-CM is applicable) or if ICD-10-CM is applicable, diagnosis code Z12.5 (Encounter for screening for malignant neoplasm of prostate)*.

50.8 - Remittance Advice Notices

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

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

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

- Remark code M140 "Service is not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday."

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

If the claim for a screening prostate antigen test or screening digital rectal examination is being denied due to the absence of *ICD-9-CM* diagnosis code V76.44*, or ICD-10-CM diagnosis code Z12.5* on the claim, *use the ASC X12 835* claim adjustment reason code 47, "This (these) diagnosis(es) is (are) not covered, missing, or invalid."

60.1 - Payment

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

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

- FOBTs [CPT 82270* (HCPCS G0107*) and HCPCS G0328] are paid under the clinical laboratory fee schedule (CLFS) except reasonable cost is paid to all non-outpatient prospective payment system (OPPS) hospitals, including Critical Access Hospitals (CAHs), but not Indian Health Service (IHS) hospitals billing on type of bill (TOB) 83X. IHS hospitals billing on TOB 83X are paid the Ambulatory Surgery Center (ASC) payment amount. Other IHS hospitals (billing on TOB 13X) are paid the Office of Management and Budget (OMB)-approved all-inclusive rate (AIR), or the facility specific per visit amount as applicable. Deductible and coinsurance do not apply for these tests. See section A below for payment to Maryland waiver hospitals on TOB 13X. Payment to all hospitals for non-patient laboratory specimens on TOB 14X will be based on the CLFS, including CAHs and Maryland waiver hospitals.

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

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

- Flexible sigmoidoscopy (code G0104) is paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs; or current payment methodologies for hospitals not subject to OPPS.

- Colonoscopies (HCPCS G0105 and G0121) and barium enemas (HCPCS G0106 and G0120) are paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs or current payment methodologies for hospitals not subject to OPPS. Also colonoscopies may be performed in an ASC and when done in an ASC, the ASC rate applies. The ASC rate is the same for diagnostic and screening colonoscopies. The ASC rate is paid to IHS hospitals when the service is billed on TOB 83X.

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

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

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

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

B. Special Payment Instructions for Non-Patient Laboratory Specimen (TOB 14X) for all hospitals

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

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

60.3 - Determining High Risk for Developing Colorectal Cancer

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

A. Characteristics of the High Risk Individual

An individual at high risk for developing colorectal cancer has one or more of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;

- A family history of familial adenomatous polyposis;

- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

B. Partial List of ICD-9-CM Codes Indicating High Risk

Listed below are some examples of diagnoses that meet the high-risk criteria for colorectal cancer. This is not an all-inclusive list. There may be more instances of conditions, which may be coded and could be considered high risk at the medical directors' discretion.

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

C. Partial List of ICD-10-CM Codes Indicating High Risk

Listed below are some examples of diagnoses that meet the high-risk criteria for colorectal cancer. This is not an all-inclusive list. There may be more instances of conditions, which may be coded and could be considered high risk at the medical directors' discretion. Use ICD-10-CM codes once ICD-10 is implemented.

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

ICD-10-CM	*Description*
K50.011	*Crohn's disease of small intestine with rectal bleeding*
K50.012	*Crohn's disease of small intestine with intestinal obstruction*
K50.013	*Crohn's disease of small intestine with fistula*
K50.014	*Crohn's disease of small intestine with abscess*
K50.018	*Crohn's disease of small intestine with other complication*
K50.019	*Crohn's disease of small intestine with unspecified complications*
K50.10	*Crohn's disease of large intestine without complications*
K50.111	*Crohn's disease of large intestine with rectal bleeding*
K50.112	*Crohn's disease of large intestine with intestinal obstruction*
K50.113	*Crohn's disease of large intestine with fistula*
K50.114	*Crohn's disease of large intestine with abscess*
K50.118	*Crohn's disease of large intestine with other complication*
K50.119	*Crohn's disease of large intestine with unspecified complications*
K50.80	*Crohn's disease of both small and large intestine without complications*
K50.811	*Crohn's disease of both small and large intestine with rectal bleeding*
K50.812	*Crohn's disease of both small and large intestine with intestinal obstruction*
K50.813	*Crohn's disease of both small and large intestine with fistula*
K50.814	*Crohn's disease of both small and large intestine with abscess*
K50.818	*Crohn's disease of both small and large intestine with other complication*
K50.819	*Crohn's disease of both small and large intestine with unspecified complications*
K50.90	*Crohn's disease, unspecified, without complications*
K50.911	*Crohn's disease, unspecified, with rectal bleeding*
K50.912	*Crohn's disease, unspecified, with intestinal obstruction*
K50.913	*Crohn's disease, unspecified, with fistula*
K50.914	*Crohn's disease, unspecified, with abscess*
K50.918	*Crohn's disease, unspecified, with other complication*
K50.919	*Crohn's disease, unspecified, with unspecified complications*
K51.20	*Ulcerative (chronic) proctitis without complications*
K51.211	*Ulcerative (chronic) proctitis with rectal bleeding*
K51.212	*Ulcerative (chronic) proctitis with intestinal obstruction*
K51.213	*Ulcerative (chronic) proctitis with fistula*
K51.214	*Ulcerative (chronic) proctitis with abscess*
K51.218	*Ulcerative (chronic) proctitis with other complication*
K51.219	*Ulcerative (chronic) proctitis with unspecified complications*
K51.30	*Ulcerative (chronic) rectosigmoiditis without complications*
K51.311	*Ulcerative (chronic) rectosigmoiditis with rectal bleeding*
K51.312	*Ulcerative (chronic) rectosigmoiditis with intestinal obstruction*
K51.313	*Ulcerative (chronic) rectosigmoiditis with fistula*
K51.314	*Ulcerative (chronic) rectosigmoiditi s with abscess*
K51.318	*Ulcerative (chronic) rectosigmoiditis with other complication*
K51.319	*Ulcerative (chronic) rectosigmoiditis with unspecified complication*
K51.80	*Other ulcerative colitis without complications*
K51.80	*Other ulcerative colitis without complications*
K51.80	*Other ulcerative colitis without complications*
K51.811	*Other ulcerative colitis with rectal bleeding*
K51.812	*Other ulcerative colitis with intestinal obstruction*

ICD-10-CM	*Description*
K51.813	*Other ulcerative colitis with fistula*
K51.814	*Other ulcerative colitis with abscess*
K51.818	*Other ulcerative colitis with other complication*
K51.819	*Other ulcerative colitis with unspecified complications*
K51.90	*Ulcerative colitis, unspecified, without complications*
K51.911	*Ulcerative colitis, unspecified with rectal bleeding*
K51.912	*Ulcerative colitis, unspecified with intestinal obstruction*
K51.913	*Ulcerative colitis, unspecified with fistula*
K51.914	*Ulcerative colitis, unspecified with abscess*
K51.918	*Ulcerative colitis, unspecified with other complication*
K51.919	*Ulcerative colitis, unspecified with unspecified complications*
K52.1	*Toxic gastroenteritis and colitis*
K52.89	*Other specified noninfective gastroenteritis and colitis*
K52.9	*Noninfective gastroenteritis and colitis, unspecified*
Z12.12	*Encounter for screening for malignant neoplasm of rectum*
Z15.09	*Genetic susceptibility to other malignant neoplasm*
Z80.0	*Family history of malignant neoplasm of digestive organs*
Z83.71	*Family history of colonic polyps*
Z85.038	*Personal history of other malignant neoplasm of large intestine*
Z85.048	*Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus*

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

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

Follow the general bill review instructions in chapter 25. Hospitals use the *ASC X12 837 institutional claim format* to bill the *A/B MAC (A)* or the hardcopy Form CMS-1450 (UB-04). Hospitals bill revenue codes and HCPCS codes as follows:

Screening Tests/Procedures	Revenue Codes	HCPCS Codes	TOBs
FOBT	030X	82270*** (G0107***), G0328	12X, 13X, 14X**, 22X, 23X, 83X, 85X
Barium enema	032X	G0106, G0120, G0122	12X, 13X, 22X, 23X, 85X****
Flexible Sigmoidoscopy	*	G0104	12X, 13X, 22X, 23X, 85X****
Colonoscopy-high risk	*	G0105, G0121	12X, 13X, 22X, 23X, 85X****
Multitarget sDNA - Cologuard™	030X	G0464	13X, 14X**, 85X

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

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

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

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

Special Billing Instructions for Hospital Inpatients

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

60.8 - Remittance Advice Codes

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

All messages refer to *ASC X12 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 fecal-occult blood test, a screening colonoscopy, a screening flexible sigmoidoscopy, or a screening barium enema is being denied because the time period between the test/procedure has not passed, use:

- CARC 119 “Benefit maximum for this time period has been reached” at the line level.

C. If the claim is being denied for a screening colonoscopy (HCPCS G0105) or a screening barium enema (HCPCS G0120) because the patient is not at a high risk, use:

- CARC 46 “This (these) service(s) is (are) not covered” at the line level; and
- RARC M83 “Service is not covered unless the patient is classified as a high risk.” at the line level.

D. If the service is being denied because payment has already been made for a similar procedure within the set time frame, use:

- CARC 18, “Duplicate claim/service” at the line level; and

- RARC M86 “Service is denied because payment already made for similar procedure within a set timeframe.” at the line level.

E. If the claim is being denied for a noncovered screening procedure such as HCPCS G0122, use:

- CARC 49, “These are noncovered services because this is a routine exam or screening procedure done in conjunction with a routine exam.”

F. If the claim is being denied because the code is invalid, use the following at the line level:

- CARC B18 “Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.”

G. If denying claims for Cologuard™ multitarget sDNA screening test (HCPCS G0464) when furnished more than once in a 3-year period [at least 2 years and 11 full months (35 months total) must elapse from the date of the last screening], use:

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

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

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

H. If denying claims for Cologuard™ multitarget sDNA screening test (HCPCS G0464) when beneficiary is not between the ages 50-85, use:

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

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

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

I. If denying claims for Cologuard™ multitarget sDNA screening test (HCPCS G0464) when the claim does not contain diagnosis codes V76.41 and V76.51 (ICD-10: Z12.12 and Z12.11 when effective), use:

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

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

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

J. If denying claims for Cologuard™ multitarget sDNA screening test (HCPCS G0464) when claims are submitted on a TOB other than 13X, 14X, or 85X, use:

- CARC 170: "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

- RARC N95 – "This provider type/provider specialty may not bill this service."

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

70.1 - Claims Submission Requirements and Applicable HCPCS Codes

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

70.1.1 - HCPCS and Diagnosis Coding

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

The following HCPCS codes should be reported when billing for screening glaucoma services:

G0117 - Glaucoma screening for high-risk patients furnished by an optometrist (physician for *A/B MAC (B)*) or ophthalmologist.

G0118 - Glaucoma screening for high-risk patients furnished under the direct supervision of an optometrist (physician for *A/B MAC (B)* or ophthalmologist.

The *A/B MAC (B)* claims type of service for the above G codes is: TOS Q.

Glaucoma screening claims should be billed using screening ("V") code V80.1 (Special Screening for Neurological, Eye, and Ear Diseases, Glaucoma)*, or if ICD-10-CM is applicable, diagnosis code Z13.5 (encounter for screening for eye and ear disorders)*. Claims submitted without a screening diagnosis code may be returned to the provider as unprocessable (refer to chapter 1 *of this manual* for more information about incomplete or invalid claims).

70.4 - Remittance Advice Notices

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

Appropriate remittance advice(s) must be used by *A/B MACs (A) and (B)* when denying payment for glaucoma screening. The following messages are used where applicable:

- If the services were furnished before January 1, 2002, use existing *ASC X12 835* remittance advice claim adjustment reason code 26 "Expenses incurred prior to coverage" at the line level.

- If the claim for glaucoma screening is being denied because the minimum time period has not elapsed since the performance of the same Medicare covered procedure, use existing *ASC X12 835* claim adjustment reason code 119 "Benefit maximum for this time period has been reached" at the line level.

- If the service is being denied because the individual is not an African-American age 50 or over, use existing remittance advice claim adjustment reason code 6, "The procedure code is inconsistent with the patient's

age," and existing remark codes M83, "Service not covered unless the patient is classified as at high risk," and M82, "Service not covered when patient is under age 50." Report these codes at the line level.

- If the service is being denied because the individual is not a Hispanic-American age 65 or over, use existing remittance advice claim adjustment reason code 96, "Non-covered charge," and existing remark codes M83, "Service not covered unless the patient is classified as at high risk," and N129, "This amount represents the dollar amount not eligible due to patient's age."

- If the service is being denied because the patient does not have diabetes mellitus, or there is no family history of glaucoma, *A/B MACs (B)* use existing remittance advice claim adjustment reason code B5, "Payment adjusted because coverage/program guidelines were not met or were exceeded." The zero payment for the service will indicate the denial. In addition, report remark code M83, "Service is not covered unless the patient is classified as at high risk" at the line level.

80.2 - A/B Medicare Administrative Contractor (MAC) *(B)* Billing Requirements

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

Effective for dates of service on and after January 1, 2005, through December 31, 2008, contractors shall recognize the HCPCS codes G0344, G0366, G0367, and G0368 shown above in §80.1 for an IPPE. The type of service (TOS) for each of these codes is as follows:

G0344: TOS = 1
G0366: TOS = 5
G0367: TOS = 5
G0368: TOS = 5

Contractors shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 6 months after the date the individual's first coverage begins under Medicare Part B, but only if that coverage period begins on or after January 1, 2005.

Effective for dates of service on and after January 1, 2009, contractors shall recognize the HCPCS codes G0402, G0403, G0404, and G0405 shown above in §80.1 for an IPPE. The TOS for each of these codes is as follows:

G0402: TOS = 1
G0403: TOS = 5
G0404: TOS = 5
G0405: TOS = 5

Under the MIPPA of 2008, contractors shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 12 months after the date the individual's first coverage begins under Medicare Part B only if that coverage period begins on or after January 1, 2009.

Contractors shall allow payment for a medically necessary Evaluation and Management (E/M) service at the same visit as the IPPE when it is clinically appropriate. Physicians and qualified nonphysician practitioners shall use CPT codes 99201-99215 to report an E/M with CPT modifier 25 to indicate that the E/M is a significant, separately identifiable service from the IPPE code reported (G0344 or G0402, whichever applies based on the date the IPPE is performed). Refer to chapter 12, §30.6.1.1, of this manual for the physician/practitioner billing correct coding and payment policy regarding E/M services.

If the EKG performed as a component of the IPPE is not performed by the primary physician or qualified NPP during the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring

physician or qualified NPP needs to make sure that the performing physician or entity bills the appropriate G code for the screening EKG, and **not** a CPT code in the 93000 series. **Both the IPPE and the EKG should be billed in order for the beneficiary to receive the complete IPPE service**. Effective for dates of service on and after January 1, 2009, the screening EKG is optional and is no longer a mandated service of an IPPE if performed as a result of a referral from an IPPE.

Should the same physician or NPP need to perform an additional medically necessary EKG in the 93000 series on the same day as the IPPE, report the appropriate EKG CPT code(s) with modifier 59, indicating that the EKG is a distinct procedural service.

Physicians or qualified nonphysician practitioners shall bill the contractor the appropriate HCPCS codes for IPPE. The HCPCS codes for an IPPE and screening EKG are paid under the Medicare Physician Fee Schedule (MPFS). *See §1.3 of this chapter for waiver of cost sharing requirements of coinsurance, copayment and deductible for furnished preventive services available in Medicare.*

90.2 - *A/B MAC (B)* Billing Requirements

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

Effective for dates of service January 1, 2005 and later, *A/B MAC (B)* shall recognize the above HCPCS codes for diabetes screening.

A/B MACs (B) shall pay for diabetes screening once every 12 months for a beneficiary that is not pre-diabetic. *A/B MACs (B)* shall pay for diabetes screening at a frequency of once every 6 months for a beneficiary that meets the definition of pre-diabetes.

A claim that is submitted for diabetes screening by a physician or supplier for a beneficiary that does not meet the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82947, 82950 or 82951 with a diagnosis code of V77.1 *(if ICD-9-CM is applicable) or (if ICD-10-CM is applicable) diagnosis code Z13.1, encounter for screening for diabetes mellitis* reported in the header.

90.2.1 - Modifier Requirements for Pre-diabetes

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

A claim that is submitted for diabetes screening and the beneficiary meets the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82497, 82950 or 82951 with a*n ICD-9-CM* diagnosis code of V77.1 reported *(if ICD-9-CM is applicable) or, if ICD-10-CM is applicable, a diagnosis code of Z13.1*in the header. In addition, modifier "TS" (follow-up service) shall be reported on the line item.

90.3 - *A/B MAC (A)* Billing Requirements

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

Effective for dates of service January 1, 2005 and later, *A/B MACs (A)* shall recognize the above HCPCS codes for diabetes screening.

A/B MACs (A) shall pay for diabetes screening once every 12 months for a beneficiary that is not pre-diabetic. *A/B MACs (A)* shall pay for diabetes screening at a frequency of once every 6 months for a beneficiary that meets the definition of pre-diabetes.

A claim that is submitted for diabetes screening by a physician or supplier for a beneficiary that does not meet the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82947, 82950 or 82951 with *an ICD-9-CM* diagnosis code of V77.1 *or, if ICD-10-CM is applicable, a diagnosis code of Z13.1*.

90.3.1 - Modifier Requirements for Pre-diabetes

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

A claim that is submitted for diabetes screening and the beneficiary meets the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82497, 82950 or 82951 with a diagnosis code of V77.1 *(if ICD-9-CM is applicable) or, if, ICD-10-CM is applicable, diagnosis code Z13.1*. In addition, modifier "TS" (follow-up service) - shall be reported on the line item.

90.4 - Diagnosis Code Reporting

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

A claim that is submitted for diabetes screening shall include the diagnosis code V77.1 *(if ICD-9-CM is applicable) or (if ICD-10-CM is applicable) diagnosis code Z13.1*.

90.5 - Medicare Summary Notices

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

When denying claims for diabetes screening based upon a CWF reject for 82947, 82950 or 82951 reported with *ICD-9-CM* diagnosis code V77.1 *or ICD-10-CM diagnosis code Z13.1*, contractors shall use MSN 18.4, "This service is being denied because it has not been 6 months since your last examination of this kind." (See chapter 30 section 40.3.6.4(c) for additional information on ABN's.)

100.2 - *A/B MAC (B)* Billing Requirements

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

Effective for dates of service, January 1, 2005, and later, *A/B MACs (B)* shall recognize the above HCPCS codes for Cardiovascular Disease Screening.

A/B MACs (B) shall pay for Cardiovascular Disease Screening once every 60 months.

A claim that is submitted for Cardiovascular Disease Screening shall be submitted in the following manner:

The line item shall contain 80061, 82465, 83718 or 84478 with *one of the following diagnoses:*

If ICD-9-CM is applicable
V81.0 - Special screening for ischemic heart disease,
V81.1 - Special screening for hypertension or
V81.2 - Special screening for other and unspecified cardiovascular conditions

If ICD-10-CM is applicable
Z13.6 - encounter for screening for cardiovascular disease

The appropriate diagnosis codes are reported in the header and pointed to the line item.

100.3 - *A/B MAC (A)* Billing Requirements

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

Effective for dates of service, January 1, 2005, and later, *A/B MACs (A)* shall recognize the above HCPCS codes for Cardiovascular Disease Screening.

A/B MACs (A) shall pay for Cardiovascular Disease Screening once every 60 months.

A claim that is submitted for Cardiovascular Disease Screening shall be submitted in the following manner:

The line item shall contain 80061, 82465, 83718 or 84478 with *one of the following diagnosis codes* reported in the header*:*

If ICD-9-CM is applicable
V81.0 - Special screening for ischemic heart disease,
V81.1 - Special screening for hypertension or
V81.2 - Special screening for other and unspecified cardiovascular conditions

If ICD-10-CM is applicable
Z13.6 - encounter for screening for cardiovascular disease

100.4 - Diagnosis Code Reporting

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

A claim that is submitted for Cardiovascular Disease Screening shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

If ICD-9-CM is applicable
V81.0 - Special screening for ischemic heart disease,
V81.1 - Special screening for hypertension, or
V81.2 - Special screening for other and unspecified cardiovascular conditions

If ICD-10-CM is applicable
Z13.6 - encounter for screening for cardiovascular disease

100.5 - Medicare Summary Notice

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

When denying claims for cardiovascular screening based upon a CWF reject for 80061, 82465, 83718, or 84478 billed with one or more the of the following diagnosis codes*,* contractors shall use MSN 16.54 Medicare does not pay for this many services or supplies.

ICD-9-CM
V81.0, V81.1 or V81.2,

ICD-10-CM
Z13.6

130.2 - Billing Requirements

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

Effective for dates of service December 8, 2009, and later, contractors shall recognize the above HCPCS codes for HIV screening.

Medicare contractors shall pay for voluntary HIV screening as follows in accordance with Pub. 100-03, Medicare National Coverage Determinations Manual, sections 190.14 and 210.7:

- A maximum of once annually for beneficiaries at increased risk for HIV infection (11 full months must elapse following the month the previous test was performed in order for the subsequent test to be covered), and,

- A maximum of three times per term of pregnancy for pregnant Medicare beneficiaries beginning with the date of the first test when ordered by the woman's clinician.

Claims that are submitted for HIV screening shall be submitted in the following manner:

HCPCS code G0432, G0433, or G0435 is reported with the following diagnosis codes.

Diagnoses for beneficiaries reporting increased risk factors:

- *If ICD-9-CM applies claims shall contain V73.89 (special screening for other specified viral disease) as primary, and V69.8 (other problems related to lifestyle), as secondary.*

- *If ICD-10-CM applies claims shall contain Z11.4 (encounter for screening for HIV) as primary, and Z72.89 (other problems related to lifestyle) as secondary.*

Diagnoses for beneficiaries not reporting increased risk factors:

- *If ICD-9-CM applies claims shall contain diagnosis code V73.89 only.*
- *If ICD-10-CM applies claims shall contain Z11.4 only.*

Diagnoses for pregnant beneficiaries which allow for more frequent screening:

- *If ICD-9-CM applies claims shall contain diagnosis code V73.89 as primary, and one of V22.0 (supervision of normal first pregnancy), V22.1 (supervision of other normal pregnancy), or V23.9 (supervision of unspecified high-risk pregnancy), as secondary*

- *If ICD-10-CM applies claims shall contain diagnosis code Z11.4 (encounter for screening for human immunodeficiency virus (HIV) as primary, and one of the following as secondary:*

ICD-10-CM code	***Description***
Z34.00	*Encounter for supervision of normal first pregnancy, unspecified trimester*
Z34.01	*Encounter for supervision of normal first pregnancy, first trimester*
Z34.02	*Encounter for supervision of normal first pregnancy, second trimester*

ICD-10-CM code	*Description*
Z34.03	*Encounter for supervision of normal first pregnancy, third trimester*
Z34.80	*Encounter for supervision of other normal pregnancy, unspecified trimester*
Z34.81	*Encounter for supervision of other normal pregnancy, first trimester*
Z34.82	*Encounter for supervision of other normal pregnancy, second trimester*
Z34.83	*Encounter for supervision of other normal pregnancy, third trimester*
Z34.90	*Encounter for supervision of normal pregnancy, unspecified, unspecified trimester*
Z34.91	*Encounter for supervision of normal pregnancy, unspecified, first trimester*
Z34.92	*Encounter for supervision of normal pregnancy, unspecified, second trimester*
Z34.93	*Encounter for supervision of normal pregnancy, unspecified, third trimester*
O09.90	*Supervision of high risk pregnancy, unspecified, unspecified trimester*
O09.91	*Supervision of high risk pregnancy, unspecified, first trimester*
O09.92	*Supervision of high risk pregnancy, unspecified, second trimester*
O09.93	*Supervision of high risk pregnancy, unspecified, third trimester*

130.5 - Diagnosis Code Reporting

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

A claim that is submitted for HIV screening shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

A. Increased Risk Factor Reported

- *ICD-9-CM -* V73.89 as primary and V69.8, *or V69.2* as secondary.
- *ICD-10-CM - Z11.4 as primary and Z72.89, Z72.51, Z72.52, orZ72.53 as secondary*

B. Increased risk factors are NOT reported:

- ICD-9-CM - V73.89 as primary only.
- *ICD-10-CM - Z11.4 as primary only.*

C. Pregnant Medicare beneficiaries:

- ICD-9-CM - The following diagnosis codes shall be submitted in addition to V73.89 to allow for more frequent screening than once per 12-month period:

  V22.0 - Supervision of normal first pregnancy, or,
  V22.1 - Supervision of other normal pregnancy, or,
  V23.9 - Supervision of unspecified high-risk pregnancy).

- *ICD-10-CM - The following diagnosis codes shall be submitted in addition to Z11.4 to allow for more frequent screening than once per 12-month period:*

Code	***Description***
Z34.00	*Encounter for supervision of normal first pregnancy, unspecified trimester*
Z34.01	*Encounter for supervision of normal first pregnancy, first trimester*
Z34.02	*Encounter for supervision of normal first pregnancy, second trimester*
Z34.03	*Encounter for supervision of normal first pregnancy, third trimester*
Z34.80	*Encounter for supervision of other normal pregnancy, unspecified trimester*
Z34.81	*Encounter for supervision of other normal pregnancy, first trimester*
Z34.82	*Encounter for supervision of other normal pregnancy, second trimester*
Z34.83	*Encounter for supervision of other normal pregnancy, third trimester*
Z34.90	*Encounter for supervision of normal pregnancy, unspecified, unspecified trimester*
Z34.91	*Encounter for supervision of normal pregnancy, unspecified, first trimester*
Z34.92	*Encounter for supervision of normal pregnancy, unspecified, second trimester*
Z34.93	*Encounter for supervision of normal pregnancy, unspecified, third trimester*
O09.90	*Supervision of high risk pregnancy, unspecified, unspecified trimester*
O09.91	*Supervision of high risk pregnancy, unspecified, first trimester*
O09.92	*Supervision of high risk pregnancy, unspecified, second trimester*
O09.93	*Supervision of high risk pregnancy, unspecified, third trimester*

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

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

a. When denying claims for HIV screening submitted without *(*ICD-9-CM*)* diagnosis codes V73.89, or V73.89 and V69.8, or (*ICD-10-CM) Z11.4, or Z11.4 and Z72.89, or Z11.4 and any of Z34.00, Z34.01, Z34.02, Z34.03,Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93* use the following messages:

   MSN 16.10 - "Medicare does not pay for this item or service."
   Spanish Version - "Medicare no paga por este articulo o servicio"

   CARC 167 - "This (these) diagnosis(es) is (are) not covered."

   Group Code CO - (Contractual Obligation)

b. When denying claims for HIV screening, use the following denial messages:

   MSN 15.22 - "The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service."

   Spanish Version - "La informacíón proporcionada no justifica la necesidad de esta cantidad de servicios o articulos en este periodo de tiempo por lo cual Medicare no pagará por este articulo o servicio."

   CARC 119 - "Benefit maximum for this time period or occurrence has been reached."

   Group Code - CO (Contractual obligation).

140.7 - Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claims Adjustment Reason Codes (CARCs), and Advance Beneficiary Notices (ABNs)
(Rev. 3329, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

Messages for *A/B MACs (A) and (B)*:

When paying claims for an AWV, contractors shall use the following Medicare Summary Notices (MSNs):

MSN: 18.25: - "Your Annual Wellness Visit has been approved. You will qualify for another Annual Wellness Visit 12 months after the date of this visit."

Spanish Version "Su Visita Anual de Bienestar ha sido aprobada. Usted tendrá derecho a otra Visita Anual de Bienestar 12 meses después de la fecha de esta visita."

When denying claims for a first AWV, HCPCS G0438, when a first AWV, HCPCS G0438, is already paid in history, contractors shall use the following messages:

MSN 20.12: - "This service was denied because Medicare only covers this service once a lifetime."

Spanish Version: "Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida."

CARC 149: "Lifetime benefit maximum has been reached for this service/benefit category."

RARC N117: "This service is paid only once in a patient's lifetime**.**

Group Code - PR

When denying claims for a subsequent AWV, HCPCS G0439, because a previous AWV, HCPCS G0438 or G0439, is paid in history within the past 12 months, contractors shall use the following messages:

MSN 18.26: "This service was denied because it occurred too soon after your last covered Annual Wellness Visit. Medicare only covers one Annual Wellness Visit within a 12 month period."

Spanish Version: "Este servicio fue negado porque ocurrió antes del período de 12 meses de su última Visita Anual de Bienestar. Medicare sólo paga por una Visita Anual de Bienestar dentro de un período de 12 meses."

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

RARC N130 "Consult plan benefit documents/guidelines for information about restrictions for this service."

Group Code - PR

When denying claims for an AWV, HCPCS G0438 or G0439, because an IPPE, HCPCS G0402, is paid in history with the past 12 months, contractors shall use the following messages:

(New) MSN 18.27: "This service was denied because it occurred too soon after your Initial Preventive Physical Exam."

Spanish Version: "Este servicio fue negado porque ocurrió demasiado pronto después de su examen físico preventivo inicial."

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

RARC N130: "Consult plan benefit documents/guidelines for information about restrictions for this service."

Group Code - PR

When denying claims for an AWV, HCPCS G0438 or G0439, because the services were rendered within the first 12 months after the effective date of a beneficiary's first Medicare Part B coverage period, contractors shall use the following messages:

(New) MSN 18.24: "This service was denied. Medicare doesn't cover an Annual Wellness Visit within the first 12 months of your Medicare Part B coverage. Medicare does cover a one-time initial preventive physical exam ("Welcome to Medicare" physical exam) within the first 12 months of your Medicare Part B coverage".

Spanish Version: "Este servicio fue negado. Medicare no cubre la Visita Anual de Bienestar durante los primeros 12 meses de su inscripción a la Parte B de Medicare. Medicare cubre un examen físico preventivo ("Bienvenido a Medicare") durante los primeros 12 meses de su inscripción a la Parte B de Medicare."

CARC 26: "Expenses incurred prior to coverage"

RARC N130: "Consult plan benefit documents/guidelines for information about restrictions for this service."

Group Code - PR

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

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

The CMS has created two new G codes for billing for tobacco cessation counseling services to prevent tobacco use for those individuals who use tobacco but do not have signs or symptoms of tobacco-related disease. These are in addition to the two CPT codes 99406 and 99407 that currently are used for smoking and tobacco-use cessation counseling for symptomatic individuals.

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

G0436 - Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes

Short descriptor: Tobacco-use counsel 3-10 min

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

Short descriptor: Tobacco-use counsel >10min

NOTE: The above G codes will not be active in contractors' systems until January 1, 2011. Therefore, contractors shall advise non-outpatient perspective payment system (OPPS) providers to use unlisted code 99199 to bill for counseling to prevent tobacco use and tobacco-related disease services during the interim period of August 25, 2010, through December 31, 2010.

On January 3, 2011, contractor's systems will accept the new G codes for services performed on or after August 25, 2010.

Two new C codes have been created for facilities paid under OPPS when billing for counseling to prevent tobacco use and tobacco-related disease services during the interim period of August 25, 2010, through December 31, 2010:

C9801 - Smoking and tobacco cessation counseling visit for the asymptomatic patient, intermediate, greater than 3 minutes, up to 10 minutes

Short descriptor: Tobacco-use counsel 3-10 min

C9802 - Smoking and tobacco cessation counseling visit for the asymptomatic patient, intensive, greater than 10 minutes

Short descriptor: Tobacco-use counsel >10min

Claims for smoking and tobacco use cessation counseling services G0436 and G0437 shall be submitted with *the applicable* diagnosis code*s:*

ICD-9-CM
V15.82, history of tobacco use, or
305.1, non-dependent tobacco use disorder

ICD-10-CM
F17.200, nicotine dependence, unspecified, uncomplicated,
F17.201, nicotine dependence, unspecified, in remission,
F17.210, nicotine dependence, cigarettes, uncomplicated,
F17.211, nicotine dependence, cigarettes, in remission,
F17.220, nicotine dependence, chewing tobacco, uncomplicated,
F17.221, nicotine dependence, chewing tobacco, in remission,
F17.290, nicotine dependence, other tobacco product, uncomplicated,
F17.291, nicotine dependence, other tobacco product, in remission, or
Z87.891, personal history of nicotine dependence, unspecified, uncomplicated.

Contractors shall allow payment for a medically necessary E/M service on the same day as the smoking and tobacco-use cessation counseling service when it is clinically appropriate. Physicians and qualified non-physician practitioners shall use an appropriate HCPCS code to report an E/M service with modifier -25 to indicate that the E/M service is a separately identifiable service from G0436 or G0437.

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

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

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

F17.201 - Nicotine dependence, unspecified, in remission
F17.210 - Nicotine dependence, cigarettes, uncomplicated
F17.211 - Nicotine dependence, cigarettes, in remission
F17.220 - Nicotine dependence, chewing tobacco, uncomplicated
F17.221 - Nicotine dependence, chewing tobacco, in remission
F17.290 - Nicotine dependence, other tobacco product, uncomplicated

F17.291 - Nicotine dependence, other tobacco product, in remission

or *without ICD-9-CM code* V15.82, *or if ICD-10-CM is applicable, Z87.891 or F17.200,* contractors shall use the following messages:

MSN 15.4: The information provided does not support the need for this service or item.

MSN Spanish Version: La información proporcionada no confirma la necesidad para este servicio o artículo

RARC M64 - “Missing/incomplete/invalid other diagnosis”

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

Contractors shall use Group Code CO, assigning financial liability to the provider, if a claim is received with no signed ABN on file.

When denying claims for counseling to prevent tobacco use services and smoking and tobacco-use cessation counseling services that exceed a combined total of 8 sessions within a 12-month period (G0436, G0437, 99406, 99407), contractors shall use the following messages:

MSN 20.5: “These services cannot be paid because your benefits are exhausted at this time.”

MSN Spanish Version: “Estos servicios no pueden ser pagados porque sus beneficios se han agotado.”

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

RARC N362: “The number of days or units of service exceeds our acceptable maximum.”

Contractors shall use Group Code PR, assigning financial liability to the beneficiary, if a claim is received with a signed ABN on file.

Contractors shall use Group Code CO, assigning financial liability to the provider, if a claim is received with no signed ABN on file.

170.2 - Diagnosis Code Reporting

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

A claim that is submitted for screening chlamydia, gonorrhea, syphilis, and/or hepatitis B shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

a. For claims for screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant use the following *ICD-9-CM* diagnosis codes:

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

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

- *Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; and*
- *any of*

- *Z72.89 - Other problems related to lifestyle ,*
  - *Z72.51 - High risk heterosexual behavior,*
  - *Z72.52 - High risk homosexual behavior, or*
  - *Z72.53 - High risk bisexual behavior. (These diagnosis codes are used to indicate high/increased risk for STIs).*

b. For claims for screening for syphilis in men at increased risk use the following ICD-9-CM diagnosis codes:

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

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

- *Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; and*
- *any of*
  - *Z72.89 - Other problems related to lifestyle ,*
  - *Z72.51 - High risk heterosexual behavior,*
  - *Z72.52 - High risk homosexual behavior, or*
  - *Z72.53 - High risk bisexual behavior.*

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

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

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

- *Z72.89 - Other problems related to lifestyle ,*
- *Z72.51 - High risk heterosexual behavior,*
- *Z72.52 - High risk homosexual behavior, or*
- *Z72.53 - High risk bisexual behavior.*

and *also one of the following.*

Code	***Description***
Z34.00	*Encounter for supervision of normal first pregnancy, unspecified trimester*
Z34.01	*Encounter for supervision of normal first pregnancy, first trimester*
Z34.02	*Encounter for supervision of normal first pregnancy, second trimester*
Z34.03	*Encounter for supervision of normal first pregnancy, third trimester*
Z34.80	*Encounter for supervision of other normal pregnancy, unspecified trimester*
Z34.81	*Encounter for supervision of other normal pregnancy, first trimester*

Code	*Description*
Z34.82	*Encounter for supervision of other normal pregnancy, second trimester*
Z34.83	*Encounter for supervision of other normal pregnancy, third trimester*
Z34.90	*Encounter for supervision of normal pregnancy, unspecified, unspecified trimester*
Z34.91	*Encounter for supervision of normal pregnancy, unspecified, first trimester*
Z34.92	*Encounter for supervision of normal pregnancy, unspecified, second trimester*
Z34.93	*Encounter for supervision of normal pregnancy, unspecified, third trimester*
O09.90	*Supervision of high risk pregnancy, unspecified, unspecified trimester*
O09.91	*Supervision of high risk pregnancy, unspecified, first trimester*
O09.92	*Supervision of high risk pregnancy, unspecified, second trimester*
O09.93	*Supervision of high risk pregnancy, unspecified, third trimester*

d. For claims for screening for syphilis in pregnant women use the following *ICD-9-CM* diagnosis codes:

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

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

- *Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission;*
- *and one of*

Code	*Description*
Z34.00	*Encounter for supervision of normal first pregnancy, unspecified trimester*
Z34.01	*Encounter for supervision of normal first pregnancy, first trimester*
Z34.02	*Encounter for supervision of normal first pregnancy, second trimester*
Z34.03	*Encounter for supervision of normal first pregnancy, third trimester*
Z34.80	*Encounter for supervision of other normal pregnancy, unspecified trimester*
Z34.81	*Encounter for supervision of other normal pregnancy, first trimester*
Z34.82	*Encounter for supervision of other normal pregnancy, second trimester*
Z34.83	*Encounter for supervision of other normal pregnancy, third trimester*
Z34.90	*Encounter for supervision of normal pregnancy, unspecified, unspecified trimester*
Z34.91	*Encounter for supervision of normal pregnancy, unspecified, first trimester*
Z34.92	*Encounter for supervision of normal pregnancy, unspecified, second*

Code	*Description*
	trimester
Z34.93	*Encounter for supervision of normal pregnancy, unspecified, third trimester*
O09.90	*Supervision of high risk pregnancy, unspecified, unspecified trimester*
O09.91	*Supervision of high risk pregnancy, unspecified, first trimester*
O09.92	*Supervision of high risk pregnancy, unspecified, second trimester*
O09.93	*Supervision of high risk pregnancy, unspecified, third trimester*

e. For claims for screening for syphilis in pregnant women at increased risk for STIs use the following *ICD-9-CM* diagnosis codes:

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

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

- *Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission;*
- ***and** any of:*
    - *Z72.89 - Other problems related to lifestyle, or*
    - *Z72.51 - High risk heterosexual behavior, or*
    - *Z72.52 - High risk homosexual behavior, or*
    - *Z72.53 - High risk bisexual behavior*

***and** also one of the following:*

Code	*Description*
Z34.00	*Encounter for supervision of normal first pregnancy, unspecified trimester*
Z34.01	*Encounter for supervision of normal first pregnancy, first trimester*
Z34.02	*Encounter for supervision of normal first pregnancy, second trimester*
Z34.03	*Encounter for supervision of normal first pregnancy, third trimester*
Z34.80	*Encounter for supervision of other normal pregnancy, unspecified trimester*
Z34.81	*Encounter for supervision of other normal pregnancy, first trimester*
Z34.82	*Encounter for supervision of other normal pregnancy, second trimester*
Z34.83	*Encounter for supervision of other normal pregnancy, third trimester*
Z34.90	*Encounter for supervision of normal pregnancy, unspecified, unspecified trimester*
Z34.91	*Encounter for supervision of normal pregnancy, unspecified, first trimester*
Z34.92	*Encounter for supervision of normal pregnancy, unspecified, second trimester*
Z34.93	*Encounter for supervision of normal pregnancy, unspecified, third trimester*
O09.90	*Supervision of high risk pregnancy, unspecified, unspecified trimester*
O09.91	*Supervision of high risk pregnancy, unspecified, first trimester*

Code	*Description*
O09.92	*Supervision of high risk pregnancy, unspecified, second trimester*
O09.93	*Supervision of high risk pregnancy, unspecified, third trimester*

f. For claims for screening for hepatitis B in pregnant women use the following *ICD-9-CM* diagnosis codes:

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

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

- *Z11.59 - Encounter for screening for other viral diseases,* ***and*** *any of*
- *Z34.00 - Encounter for supervision of normal first pregnancy, unspecified trimester, or*
- *Z34.80 - Encounter for supervision of other normal pregnancy, unspecified trimester, or*
- *Z34.90 - Encounter for supervision of normal pregnancy, unspecified, unspecified trimester, or*
- *O09.90 - Supervision of high risk pregnancy, unspecified, unspecified trimester.*

g. For claims for screening for hepatitis B in pregnant women at increased risk for STIs use the following *ICD-9-CM* diagnosis codes:

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

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

- *Z11.59 - Encounter for screening for other viral diseases, and*
- *Z72.89 - Other problems related to lifestyle,* ***and***
- *any of*
  - *Z72.51 - High risk heterosexual behavior, or*
  - *Z72.52 - High risk homosexual behavior, or*
  - *Z72.53 - High risk bisexual behavior;*
- ***and*** *also one of the following:*

Code	*Description*
Z34.00	*Encounter for supervision of normal first pregnancy, unspecified trimester*
Z34.01	*Encounter for supervision of normal first pregnancy, first trimester*
Z34.02	*Encounter for supervision of normal first pregnancy, second trimester*
Z34.03	*Encounter for supervision of normal first pregnancy, third trimester*
Z34.80	*Encounter for supervision of other normal pregnancy, unspecified trimester*
Z34.81	*Encounter for supervision of other normal pregnancy, first trimester*
Z34.82	*Encounter for supervision of other normal pregnancy, second trimester*

Code	*Description*
Z34.83	*Encounter for supervision of other normal pregnancy, third trimester*
Z34.90	*Encounter for supervision of normal pregnancy, unspecified, unspecified trimester*
Z34.91	*Encounter for supervision of normal pregnancy, unspecified, first trimester*
Z34.92	*Encounter for supervision of normal pregnancy, unspecified, second trimester*
Z34.93	*Encounter for supervision of normal pregnancy, unspecified, third trimester*
O09.90	*Supervision of high risk pregnancy, unspecified, unspecified trimester*
O09.91	*Supervision of high risk pregnancy, unspecified, first trimester*
O09.92	*Supervision of high risk pregnancy, unspecified, second trimester*
O09.93	*Supervision of high risk pregnancy, unspecified, third trimester*

170.3 - Billing Requirements

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

Effective for dates of service November 8, 2011, and later, contractors shall recognize HCPCS code G0445 for HIBC. Medicare shall cover up to two occurrences of G0445 when billed for HIBC to prevent STIs. A claim that is submitted with HCPCS code G0445 for HIBC shall be submitted with ICD-9-CM diagnosis code V69.8 *or ICD-10-CM diagnosis code Z72.89*.

Medicare contractors shall pay for screening for chlamydia, gonorrhea, and syphilis (as indicated by the presence of ICD-9-*CM* diagnosis code V74.5 *or if ICD-10 is applicable, ICD-10-CM diagnosis code Z11.3);* and/or hepatitis B (as indicated by the presence of ICD-9-*CM* diagnosis code V73.89 *or ICD-10-CM diagnosis code Z11.59*) as follows:

- One annual occurrence of screening for chlamydia, gonorrhea, and syphilis (i.e., 1 per 12-month period) in women at increased risk who are not pregnant,
- One annual occurrence of screening for syphilis (i.e., 1 per 12-month period) in men at increased risk,
- Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening,
- One occurrence per pregnancy of screening for syphilis in pregnant women,
- Up to an additional two occurrences per pregnancy of screening for syphilis in pregnant women if the beneficiary is at continued increased risk for STIs,
- One occurrence per pregnancy of screening for hepatitis B in pregnant women, and,
- One additional occurrence per pregnancy of screening for hepatitis B in pregnant women who are at continued increased risk for STIs.

200.1 - Policy

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

For services furnished on or after November 29, 2011, Medicare will cover Intensive Behavioral Therapy for Obesity. Medicare beneficiaries with obesity (BMI $\geq$30 kg/m^2) who are competent and alert at the time that

counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting are eligible for:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs.) weight loss requirement during the first 6 months as discussed below.

The counseling sessions are to be completed based on the 5As approach adopted by the United States Preventive Services Task Force (USPSTF.) The steps to the 5As approach are listed below:

1. **Assess**: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.

2. **Advise**: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.

3. **Agree**: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.

4. **Assist**: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.

5. **Arrange**: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Medicare will cover Face-to-Face Behavioral Counseling for Obesity, 15 minutes (G0447), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9-*CM* codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), up to 22 sessions in a 12-month period for Medicare beneficiaries. The Medicare coinsurance and Part B deductible are waived for this preventive service.

NOTE: Effective for claims with dates of service on or after January 1, 2015, codes G0473 and G0447 can be billed for a total of no more than 22 sessions in a 12-month period.

Contractors shall note the appropriate ICD-10-*CM* code(s) that are listed below for future implementation. Contractors shall track the ICD-10-*CM* codes and ensure that the updated edit is turned on when ICD-10 is implemented.

ICD-10-*CM*	Description
Z68.30	BMI 30.0-30.9, adult
Z68.31	BMI 31.0-31.9, adult
Z68.32	BMI 32.0-32.9, adult
Z68.33	BMI 33.0-33.9, adult
Z68.34	BMI 34.0-34.9, adult
Z68.35	BMI 35.0-35.9, adult
Z68.36	BMI 36.0-36.9, adult
Z68.37	BMI 37.0-37.9, adult
Z68.38	BMI 38.0-38.9, adult

Z68.39	BMI 39.0-39.9, adult
Z68.41	BMI 40.0-44.9, adult
Z68.42	BMI 45.0-49.9, adult
Z68.43	BMI 50.0-59.9, adult
Z68.44	BMI 60.0-69.9, adult
Z68.45	BMI 70 or greater, adult

See Pub. 100-03, Medicare National Coverage Determinations Manual, §210.12 for complete coverage guidelines.

200.3 - Professional Billing Requirements

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

CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, (G0447), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9*-CM* codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), *or 1 of the ICD-10-CM codes for BMI 30.0-BMI 70 (Z68.30-Z68.39 and Z68.41-Z68.45)* only when services are submitted by the following provider specialties found on the provider's enrollment record:

01 - General Practice
08 - Family Practice
11 - Internal Medicine
16 - Obstetrics/Gynecology
37 - Pediatric Medicine
38 - Geriatric Medicine
50 - Nurse Practitioner
89 - Certified Clinical Nurse Specialist
97 - Physician Assistant

Any claims that are not submitted from one of the provider specialty types noted above will be denied.

CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, (G0447), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9*-CM* codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), *or with 1 of the ICD-10-CM codes for BMI 30.0-BMI 70 (Z68.30-Z68.39 and Z68.41-Z68.45)* only when submitted with one of the following place of service (POS) codes:

11 - Physician's Office
22 - Outpatient Hospital
49 - Independent Clinic
71 - State or Local Public Health Clinic

Any claims that are not submitted with one of the POS codes noted above will be denied.

NOTE: HCPCS Code G0447 is effective November 29, 2011. HCPCS Code G0473 is effective January 1, 2015.

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

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

Contractors shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for obesity counseling sessions:

- Denying services submitted on a TOB other than 13X and 85X:

  CARC 171 - Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N428 - Not covered when performed in this place of service.

  MSN 16.2 - This service cannot be paid when provided in this location/facility.

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

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

  NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

  - Denying services for obesity counseling sessions HCPCS code G0473 or G0447 with 1 of the ICD-9*-CM* codes (V85.30-V85.39 or V85.41-V85.45) *or with one of the ICD-10-CM codes (Z68.30-Z68.39 or Z68.41-Z68.45)* when billed for a total of more than 22 sessions in the same 12-month period:

  CARC 119 - Benefit maximum for this time period or occurrence has been reached.

  RARC N362 - The number of days or units of service exceeds our acceptable maximum.

  MSN 20.5 - These services cannot be paid because your benefits are exhausted at this time.

  Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."

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

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

  NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines for obesity counseling sessions HCPCS code G0473 or G0447 without 1 of the appropriate ICD-9*-CM* codes (V85.30-V85.39 or V85.41-V85.45) *or 1 of the ICD-10-CM codes (Z68.30-Z68.39 or Z68.41-Z68.45)*:

  CARC 167 - "This (these) diagnosis(es) is (are) not covered. Note: Refer to the *ASC X12* 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

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

MSN 14.9 - "Medicare cannot pay for this service for the diagnosis shown on the claim."

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

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

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines without the appropriate POS code:

CARC 5 - The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC M77 - Missing/incomplete/invalid place of service.

MSN 21.25 - This service was denied because Medicare only covers this service in certain settings.

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

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines that are not submitted from the appropriate provider specialties:

CARC 8 - "The procedure code is inconsistent with the provider type/specialty (taxonomy). NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

RARC N95 - "This provider type/provider specialty may not bill this service."

MSN 21.18 - "This item or service is not covered when performed or ordered by this provider."

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

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

200.5 - Common Working File (CWF) Edits

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

When applying frequency, CWF shall count 22 counseling sessions of any of G0473 and/or G0447 (for a total of no more than 22 sessions in the same 12-month period) along with 1 ICD-9-*CM* code from V85.30-V85.39 or V85.41-V85.45 in a 12-month period, *or if ICD-10 is applicable with 1 ICD-10-CM code from Z68.30-Z68.39 or Z68.41-Z68.45*. When applying frequency limitations to G0473 or G0447 counseling CWF shall allow both a claim for the professional service and a claim for a facility fee. CWF shall identify the following

institutional claims as facility fee claims for this service: TOB 13X, TOB 85X when the revenue code is not 096X, 097X, or 098X. CWF shall identify all other claims as professional service claims.