CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13549	**Date: December 18, 2025**
	Change Request 14267

SUBJECT: Update to the Internet Only Manual (IOM) Publication 100-04, Chapter 18, Sections 150.1, 150.2.1, 150.3 and Chapter 32, Sections 12.1, 12.3, 320.3.3, 400.2.2, 400.2.3 and 400.2.3.1 for Coding Revisions to National Coverage Determination (NCDs) - October 2025 Change Request (CR) 14041

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Publication (Pub.) 100-04, Chapter 18, Sections 150.1, 150.2.1, 150.3 and Chapter 32, Sections 12.1, 12.3, 320.3.3, 400.2.2, 400.2.3 and 400.2.3.1 of the Medicare Claims Processing Manual to coincide with the National Coverage Determination (NCD) updates in CR 14041, "International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to the National Coverage Determination (NCDs) - October 2025."

EFFECTIVE DATE: January 20, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 20, 2026

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/150/150.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Coding
R	18/150/150.2.1/A/B MAC (A) and (HHH) Billing Requirements
R	18/150/150.3/Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claims Adjustment Reason Codes (CARCs), and Group Codes
R	32/12/12.1/ Counseling to Prevent Tobacco Use HCPCS and Diagnosis Coding
R	32/12/12.3/A/B MAC (A) Billing Requirements
R	32/320/320.3.3/Other
R	32/400/400.2.2/A/B MAC (A) Revenue Code
R	32/400/400.2.3/A/B MAC Billing HCPCS Codes
R	32/400/400.2.3.1/A/B MAC (B) Places of Service (POS)

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: 13549	Date: December 18, 2025	Change Request: 14267

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II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update the billing requirements in Pub.100-04, Chapter 18, Sections 150.1, 150.2.1, 150.3 and Chapter 32, Sections 12.1, 12.3, 320.3.3, 400.2.2, 400.2.3 and 400.2.3.1 of the Medicare Claims Processing Manual. The revisions listed below can be found in CR 14041, International Classification of Diseases,10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)-October 2025.

NCD 20.9.1 - Ventricular Assist Devices: Add ICD-10 diagnosis code Z95.811 effective December 1, 2020. (Pub. 100-04 Chapter 32, Section 320.3.3)

NCD 110.24 - CAR-T: Add Healthcare Common Procedure Coding System (HCPCS) code Q2058 effective July 1, 2025, and HCPCS code C9301 for dates of service April 1, 2025–June 30, 2025. (Pub. 100-04 Chapter 32, Sections 400.2.2, 400.2.3 and 400 2.3.1.)

NCD 210.4.1 - Counseling to Prevent Tobacco Use - Add ICD-10 diagnosis code Z72.0 Tobacco Use effective October 1, 2024, and allow revenue code 0519 for Federally Qualified Health Centers (FQHC) (Pub. 100-04 Chapter 18, Sections 150.1, 150.2.1 and 150.3 and Chapter 32, Sections 12.1 and 12.3.)

B. Policy: This CR does not involve any changes to policy.

III. 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	
14267.1	Contractors shall be aware of the manual updates in Pub.100-04 Chapter 32, Section 320.3.3. Note: Add ICD-10 diagnosis code Z95.811 effective December 1, 2020.	X	X							
14267.2	Contractors shall be aware of the manual updates in Pub.100-04 Chapter 32, Sections 400.2.2, 400.2.3 and 400.2.3.1. Note: Add Healthcare Common Procedure Coding System (HCPCS) code Q2058 effective July 1, 2025, and HCPCS code C9301 effective for dates of services April 1, 2025–June 30, 2025.	X	X							
14267.3	Contractors shall be aware of the manual updates in Pub.100-04 Chapter 18, Sections 150.1, 150.2.1 and 150.3 and Chapter 32, Sections 12.1 and 12.3. Note: Add ICD-10 diagnosis code Z72.0 Tobacco Use effective October 1, 2024, and allow revenue code 0519 for Federally Qualified Health Centers (FQHC).	X	X							

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. 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

VI. CONTACTS

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

VII. 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

Table of Contents
(Rev. 13549; Issued: 12-18-25)

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

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively. See Chapter 32 section 12 for coverage and billing requirements for smoking cessation services.

The CMS has created two new CPT 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.

The two CPT codes 99406 or 99407 that currently are used for smoking and tobacco-use cessation counseling for symptomatic individuals.

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

On January 3, 2011, A/B MAC (A), (B), and (HHH) systems will accept the new G codes for services performed on or after August 25, 2010.

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

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

Short descriptor: Tobacco-use counsel 3-10 min

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

Short descriptor: Tobacco-use counsel >10min

Claims for smoking and tobacco use cessation counseling services 99406 or 99407 shall be submitted with the applicable diagnosis codes:

ICD-10 CM Code	*Code Description*
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17.220	Nicotine dependence, chewing tobacco, uncomplicated
F17.221	Nicotine dependence, chewing tobacco, in remission
F17.223	Nicotine dependence, chewing tobacco, with withdrawal
F17.228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17.229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
F17.290	Nicotine dependence, other tobacco product, uncomplicated
F17.291	Nicotine dependence, other tobacco product, in remission
F17.293	Nicotine dependence, other tobacco product, with withdrawal
F17.298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17.299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
T65.211A	Toxic effect of chewing tobacco, accidental (unintentional), initial encounter
T65.212A	Toxic effect of chewing tobacco, intentional self-harm, initial encounter
T65.213A	Toxic effect of chewing tobacco, assault, initial encounter
T65.214A	Toxic effect of chewing tobacco, undetermined, initial encounter
T65.221A	Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter
T65.222A	Toxic effect of tobacco cigarettes, intentional self-harm, initial encounter
T65.223A	Toxic effect of tobacco cigarettes, assault, initial encounter
T65.224A	Toxic effect of tobacco cigarettes, undetermined, initial encounter
T65.291A	Toxic effect of other tobacco and nicotine, accidental (unintentional), initial encounter
T65.292A	Toxic effect of other tobacco and nicotine, intentional self-harm, initial encounter
T65.293A	Toxic effect of other tobacco and nicotine, assault, initial encounter
T65.294A	Toxic effect of other tobacco and nicotine, undetermined, initial encounter
Z72.0	*Tobacco use effective October 1, 2024*
Z87.891	Personal history of nicotine dependence

A/B MAC (A), (B), and (HHH) shall allow payment for a medically necessary E/M service on the same day as the smoking and tobacco-use cessation counseling service

when it is clinically appropriate. Physicians and qualified non-physician practitioners shall use an appropriate HCPCS code to report an E/M service with modifier -25 to indicate that the E/M service is a separately identifiable service from 99406 or 99407.

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

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

The A/B MACs (A) and (HHH) shall pay for counseling to prevent tobacco use services with codes G0436 and G0437 for dates of service on or after January 1, 2011. A/B MACs (A) and (HHH) shall pay for counseling services billed with code 99199 for dates of service performed on or after August 25, 2010, through December 31, 2010. For facilities paid under OPPS, A/B MACs (A) shall pay for counseling services billed with codes C9801 and C9802 for dates of service performed on or after August 25, 2010, through December 31, 2010.

Claims for counseling to prevent tobacco use services should be submitted on Form CMS-1450 or its electronic equivalent.

The applicable bill types are 12X, 13X, 22X, 23X, 34X, 71X, 77X, and 85X.

Applicable revenue codes are as follows:

Provider Type	***Revenue Code***
Rural Health Centers (RHCs)	*052X*
Federally Qualified Health Centers (FQHCs)	*052x, 0519*
Indian Health Services (IHS)	*0510*
Critical Access Hospitals (CAHs) Method II	*096X, 097X, 098X*
All Other Providers	*0942*

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

The applicable bill types are 12X, 13X, 22X, 23X, 34X, 71X, 77X, and 85X. Payment for outpatient services is as follows:

Type of Facility	***Method of Payment***
Rural Health Centers (RHCs) *Type of Bill (*TOB*)* 71X	All-inclusive rate (AIR) for the encounter
Federally Qualified Health Centers (FQHCs) TOB 77X	*FQHC Prospective Payment System (PPS) for the encounter*
Hospitals TOBs 12X and 13X	OPPS for hospitals subject to OPPS MPFS for hospitals not subject to OPPS
Indian Health Services (IHS) Hospitals TOB 13X	AIR for the encounter
Skilled Nursing Facilities (SNFs) TOBs 22X and 23X	Medicare Physician Fee Schedule (MPFS)
Home Health Agencies (HHAs) TOB 34X	MPFS

Critical Access Hospitals (CAHs) TOB 85X	Method I: Technical services are paid at 101% of reasonable cost. Method II: technical services are paid at 101% of reasonable cost, and Professional services are paid at 115% of the MPFS Data Base
IHS CAHs TOB 85X	Based on specific rate
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC). That is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

Deductible and coinsurance apply for services performed on August 25, 2010, through December 31, 2010. For claims with dates of service on and after January 1, 2011, coinsurance and deductible do not apply for G0436 and G0437.

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

NOTE: Section 4104 of ACA provided for a waiver of Medicare coinsurance and Part B deductible for this service effective on or after 1/1/11. Copayment/coinsurance waived; Deductible waived for HCPCS G0436 & G0437 through 9/30/16, for CPT codes 99406 & 99407 effective 10/1/16.

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

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

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

ICD-10 CM Code	*Code Description*
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17.220	Nicotine dependence, chewing tobacco, uncomplicated
F17.221	Nicotine dependence, chewing tobacco, in remission
F17.223	Nicotine dependence, chewing tobacco, with withdrawal
F17.228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17.229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
F17.290	Nicotine dependence, other tobacco product, uncomplicated
F17.291	Nicotine dependence, other tobacco product, in remission
F17.293	Nicotine dependence, other tobacco product, with withdrawal
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F17.299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
T65.211A	Toxic effect of chewing tobacco, accidental (unintentional), initial encounter
T65.212A	Toxic effect of chewing tobacco, intentional self-harm, initial encounter
T65.213A	Toxic effect of chewing tobacco, assault, initial encounter
T65.214A	Toxic effect of chewing tobacco, undetermined, initial encounter
T65.221A	Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter
T65.222A	Toxic effect of tobacco cigarettes, intentional self-harm, initial encounter
T65.223A	Toxic effect of tobacco cigarettes, assault, initial encounter
T65.224A	Toxic effect of tobacco cigarettes, undetermined, initial encounter
T65.291A	Toxic effect of other tobacco and nicotine, accidental (unintentional), initial encounter
T65.292A	Toxic effect of other tobacco and nicotine, intentional self-harm, initial encounter
T65.293A	Toxic effect of other tobacco and nicotine, assault, initial encounter
T65.294A	Toxic effect of other tobacco and nicotine, undetermined, initial encounter
Z72.0	*Tobacco use effective October 1, 2024*
Z87.891	Personal history of nicotine dependence

or without above ICD-10-CM is applicable Part A/B MACs (A), (B), or (HHH) shall use the following messages:

CARC 16 – “Claim/service lacks information or has submission/billing error(s).”

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

A/B MACs (A), (B), or (HHH) shall use Group Code CO, assigning financial liability to the provider, if a claim is received with no signed ABN on file.

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

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

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

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

A/B MACs (A), (B), or (HHH) shall use Group Code PR, assigning financial liability to the beneficiary, if a claim is received with a signed ABN on file.

A/B MACs (A), (B), or (HHH) shall use Group Code CO, assigning financial liability to the provider, if a claim is received with no signed ABN on file.

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.

Medicare Claims Processing Manual
Chapter 32 – Billing Requirements for Special Services

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(Rev. 13549; Issued: 12-18-25)

12.1 - Counseling to Prevent Tobacco Use HCPCS and Diagnosis Coding

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

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

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

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

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

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

Contractors shall only pay for 8 counseling to prevent tobacco use sessions in a 12-month period. The beneficiary may receive another 8 sessions during a second or subsequent year after 11 full months have passed since the first Medicare covered counseling session was performed. To start the count for the second or subsequent 12-month period, begin with the month after the month in which the first Medicare covered counseling session was performed and count until 11 full months have elapsed.

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

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

ICD-9-CM (prior to October 1, 2015)
V15.82, personal history of tobacco use, or
305.1, non-dependent tobacco use disorder
989.84, toxic effect of tobacco

ICD-10-CM (effective October 1, 2015)
F17.210, nicotine dependence, cigarettes, uncomplicated,
F17.211, nicotine dependence, cigarettes, in remission,
F17.213 Nicotine dependence, cigarettes, with withdrawal

F17.218 Nicotine dependence, cigarettes, with other nicotine-induced disorders

F17.219 Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders

F17.220, nicotine dependence, chewing tobacco, uncomplicated,
F17.221, nicotine dependence, chewing tobacco, in remission,
F17.223 Nicotine dependence, chewing tobacco, with withdrawal

F17.228 Nicotine dependence, chewing tobacco, with other nicotine-induced disorders

F17.229 Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders

F17.290, nicotine dependence, other tobacco product, uncomplicated,
F17.291, nicotine dependence, other tobacco product, in remission, or
F17.293 Nicotine dependence, other tobacco product, with withdrawal

F17.298 Nicotine dependence, other tobacco product, with other nicotine-induced disorders

F17.299 Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders

Z87.891, personal history of nicotine dependence, unspecified, uncomplicated.
T65.211A, Toxic effect of chewing tobacco, accidental (unintentional), initial encounter
T65.212A, Toxic effect of chewing tobacco, intentional self-harm, initial encounter
T65.213A, Toxic effect of chewing tobacco, assault, initial encounter
T65.214A, Toxic effect of chewing tobacco, undetermined, initial encounter
T65.221A, Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter
T65.222A, Toxic effect of tobacco cigarettes, intentional self-harm, initial encounter
T65.223A, Toxic effect of tobacco cigarettes, assault, initial encounter
T65.224A, Toxic effect of tobacco cigarettes, undetermined, initial encounter
T65.291A, Toxic effect of other tobacco and nicotine, accidental (unintentional), initial encounter
T65.292A, Toxic effect of other tobacco and nicotine, intentional self-harm, initial encounter
T65.293A, Toxic effect of other tobacco and nicotine, assault, initial encounter
T65.294A, Toxic effect of other tobacco and nicotine, undetermined, initial encounter
Z72.0, Tobacco use effective October 1, 2024

12.3 - A/B MAC (A) Billing Requirements

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

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

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

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

Applicable revenue codes are as follows:

Provider Type	Revenue Code
Rural Health Centers (RHCs)	052X
Federally Qualified Health Centers (FQHCs)	*052X, 0519*
Indian Health Services (IHS)	0510
Critical Access Hospitals (CAHs) Method II	096X, 097X, 098X
All Other Providers	0942

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

Payment for outpatient services is as follows:

Type of Facility	Method of Payment
Rural Health Centers (RHCs)	All-inclusive rate (AIR) for the encounter
Federally Qualified Health Centers (FQHCs)	FQHC Prospective Payment System (PPS) for the encounter
Indian Health Service (IHS)/Tribally owned or operated hospitals and hospital-based facilities	AIR
IHS/Tribally owned or operated non-hospital-based facilities	Medicare Physician Fee Schedule (MPFS)
IHS/Tribally owned or operated Critical Access Hospitals (CAHs)	Facility Specific Visit Rate
Hospitals subject to the Outpatient Prospective Payment System (OPPS)	Ambulatory Payment Classification (APC)
Hospitals not subject to OPPS	Payment is made under current methodologies
Skilled Nursing Facilities (SNFs) **NOTE:** Included in Part A PPS for skilled patients.	MPFS

Home Health Agencies (HHAs)	MPFS
Critical Access Hospitals (CAHs)	Method I: Technical services are paid at 101% of reasonable cost. Method II: technical services are paid at 101% of reasonable cost, and Professional services are paid at 115% of the MPFS Data Base
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC). That is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

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

320.3.3 – Other

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

All other indications for the use of VADs not otherwise listed remain non-covered, except in the context of Category B investigational device exemption clinical trials (42 CFR 405) or as a routine cost in clinical trials defined under section 310.1 of the NCD Manual.

Claims Coding

Appropriate ICD-10 diagnosis and procedure codes are included below:

ICD-10 Diagnosis Code	***Definition***
I09.81	*Rheumatic heart failure*
I11.0	*Hypertensive heart disease with heart failure*
I13.0	*Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease*
I13.2	*Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease*
I20.0	*Unstable angina*
I20.2	*Refractory angina pectoris*
I21.01	*ST elevation (STEMI) myocardial infarction involving left main coronary artery*
I21.02	*ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery*
I21.09	*ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall*
I21.11	*ST elevation (STEMI) myocardial infarction involving right coronary artery*
I21.19	*ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall*
I21.21	*ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery*

I21.29	*ST elevation (STEMI) myocardial infarction involving other sites*
I21.3	*ST elevation (STEMI) myocardial infarction of unspecified site*
I21.4	*Non-ST elevation (NSTEMI) myocardial infarction*
I22.0	*Subsequent ST elevation (STEMI) myocardial infarction of anterior wall*
I22.1	*Subsequent ST elevation (STEMI) myocardial infarction of inferior wall*
I22.2	*Subsequent non-ST elevation (NSTEMI) myocardial infarction*
I22.8	*Subsequent ST elevation (STEMI) myocardial infarction of other sites*
I22.9	*Subsequent ST elevation (STEMI) myocardial infarction of unspecified site*
I24.0	*Acute coronary thrombosis not resulting in myocardial infarction*
I24.1	*Dressler's syndrome*
I24.81	*Acute coronary microvascular dysfunction Effective 10/1/23*

ICD-10 Diagnosis Code	***Definition***
I24.89	*Other forms of acute ischemic heart disease Effective 10/1/23*
I24.9	*Acute ischemic heart disease, unspecified*
I25.10	*Atherosclerotic heart disease of native coronary artery without angina pectoris*
I25.110	*Atherosclerotic heart disease of native coronary artery with unstable angina pectoris*
I25.111	*Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm*
I25.112	*Atherosclerotic heart disease of native coronary artery with refractory angina pectoris*
I25.118	*Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris*
I25.119	*Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris*
I25.5	*Ischemic cardiomyopathy*
I25.6	*Silent myocardial ischemia*
I25.700	*Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris*
I25.701	*Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm*
I25.702	*Atherosclerosis of coronary artery bypass graft(s), unspecified, with refractory angina pectoris*
I25.708	*Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris*
I25.709	*Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris*
I25.710	*Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris*
I25.711	*Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm*
I25.712	*Atherosclerosis of autologous vein coronary artery bypass graft(s) with refractory angina pectoris*
I25.718	*Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris*

I25.719	*Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris*
I25.720	*Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris*
I25.721	*Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm*
I25.722	*Atherosclerosis of autologous artery coronary artery bypass graft(s) with refractory angina pectoris*
I25.728	*Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris*
I25.729	*Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris*
I25.730	*Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris*
I25.731	*Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm*

ICD-10 Diagnosis Code	***Definition***
I25.732	*Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with refractory angina pectoris*
I25.738	*Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris*
I25.739	*Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris*
I25.750	*Atherosclerosis of native coronary artery of transplanted heart with unstable angina*
I25.751	*Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm*
I25.752	*Atherosclerosis of native coronary artery of transplanted heart with refractory angina pectoris*
I25.758	*Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris*
I25.759	*Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris*
I25.760	*Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina*
I25.761	*Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm*
I25.762	*Atherosclerosis of bypass graft of coronary artery of transplanted heart with refractory angina pectoris*
I25.768	*Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris*
I25.769	*Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris*
I25.790	*Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris*

I25.791	*Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm*
I25.792	*Atherosclerosis of other coronary artery bypass graft(s) with refractory angina pectoris*
I25.798	*Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris*
I25.799	*Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris*
I25.810	*Atherosclerosis of coronary artery bypass graft(s) without angina pectoris*
I25.811	*Atherosclerosis of native coronary artery of transplanted heart without angina pectoris*
I25.812	*Atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris*
I25.89	*Other forms of chronic ischemic heart disease*
I25.9	*Chronic ischemic heart disease, unspecified*
I34.0	*Nonrheumatic mitral (valve) insufficiency*
I34.1	*Nonrheumatic mitral (valve) prolapse*
I34.2	*Nonrheumatic mitral (valve) stenosis*
I34.81	*Nonrheumatic mitral (valve)*
I34.89	*Other nonrheumatic mitral valve disorders*
I34.9	*Nonrheumatic mitral valve disorder, unspecified*
I35.0	*Nonrheumatic aortic (valve) stenosis*
I35.1	*Nonrheumatic aortic (valve) insufficiency*
I35.2	*Nonrheumatic aortic (valve) stenosis with insufficiency*
I35.8	*Other nonrheumatic aortic valve disorders*
I35.9	*Nonrheumatic aortic valve disorder, unspecified*

ICD-10 Diagnosis Code	***Definition***
I36.0	*Nonrheumatic tricuspid (valve) stenosis*
I36.1	*Nonrheumatic tricuspid (valve) insufficiency*
I36.2	*Nonrheumatic tricuspid (valve) stenosis with insufficiency*
I36.8	*Other nonrheumatic tricuspid valve disorders*
I36.9	*Nonrheumatic tricuspid valve disorder, unspecified*
I37.0	*Nonrheumatic pulmonary valve stenosis*
I37.1	*Nonrheumatic pulmonary valve insufficiency*
I37.2	*Nonrheumatic pulmonary valve stenosis with insufficiency*
I37.8	*Other nonrheumatic pulmonary valve disorders*
I37.9	*Nonrheumatic pulmonary valve disorder, unspecified*
I38	*Endocarditis, valve unspecified*
I39	*Endocarditis and heart valve disorders in diseases classified elsewhere*
I42.0	*Dilated cardiomyopathy*
I42.2	*Other hypertrophic cardiomyopathy*
I42.3	*Endomyocardial (eosinophilic) disease*

I42.4	*Endocardial fibroelastosis*
I42.5	*Other restrictive cardiomyopathy*
I42.6	*Alcoholic cardiomyopathy*
I42.7	*Cardiomyopathy due to drug and external agent*
I42.8	*Other cardiomyopathies*
I42.9	*Cardiomyopathy, unspecified*
I43	*Cardiomyopathy in diseases classified elsewhere*
I46.2	*Cardiac arrest due to underlying cardiac condition*
I46.8	*Cardiac arrest due to other underlying condition*
I46.9	*Cardiac arrest, cause unspecified*
I47.0	*Re-entry ventricular arrhythmia*
I47.10	*Supraventricular tachycardia, unspecified Effective 10/1/23*
I47.11	*Inappropriate sinus tachycardia, so stated Effective 10/1/23*
I47.19	*Other supraventricular tachycardia Effective 10/1/23*
I47.20	*Ventricular tachycardia, unspecified*
I47.21	*Torsades de pointes*
I47.29	*Other ventricular tachycardia*
I47.9	*Paroxysmal tachycardia, unspecified*
I48.0	*Atrial fibrillation*
I48.11	*Longstanding persistent atrial fibrillation*
I48.19	*Other persistent atrial fibrillation*
I49.01	*Ventricular fibrillation*
I49.02	*Ventricular flutter*
I49.1	*Atrial premature depolarization*
I49.2	*Junctional premature depolarization*

ICD-10 Diagnosis Code	***Definition***
I49.3	*Ventricular premature depolarization*
I49.40	*Unspecified premature depolarization*
I49.49	*Other premature depolarization*
I49.5	*Sick sinus syndrome*
I49.8	*Other specified cardiac arrhythmias*
I49.9	*Cardiac arrhythmia, unspecified*
I50.1	*Left ventricular failure*
I50.20	*Unspecified systolic (congestive) heart failure*
I50.21	*Acute systolic (congestive) heart failure*
I50.22	*Chronic systolic (congestive) heart failure*
I50.23	*Acute on chronic systolic (congestive) heart failure*
I50.30	*Unspecified diastolic (congestive) heart failure*
I50.31	*Acute diastolic (congestive) heart failure*
I50.32	*Chronic diastolic (congestive) heart failure*
I50.33	*Acute on chronic diastolic (congestive) heart failure*
I50.40	*Unspecified combined systolic (congestive) and diastolic (congestive) heart failure*

I50.41	*Acute combined systolic (congestive) and diastolic (congestive) heart failure*
I50.42	*Chronic combined systolic (congestive) and diastolic (congestive) heart failure*
I50.43	*Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure*
I50.84	*End-stage heart failure*
I50.9	*Heart failure, unspecified*
I51.4	*Myocarditis, unspecified*
I51.9	*Heart disease, unspecified*
I52	*Other heart disorders in diseases classified elsewhere*
I5A	*Non-ischemic myocardial injury (non-traumatic)*
I97.0	*Postcardiotomy syndrome*
I97.110	*Postprocedural cardiac insufficiency following cardiac surgery*
I97.111	*Postprocedural cardiac insufficiency following other surgery*
I97.120	*Postprocedural cardiac arrest following cardiac surgery*
I97.121	*Postprocedural cardiac arrest following other surgery*
I97.130	*Postprocedural heart failure following cardiac surgery*
I97.131	*Postprocedural heart failure following other surgery*
I97.190	*Other postprocedural cardiac functional disturbances following cardiac surgery*
I97.191	*Other postprocedural cardiac functional disturbances following other surgery*
I97.710	*Intraoperative cardiac arrest during cardiac surgery*
I97.711	*Intraoperative cardiac arrest during other surgery*
I97.790	*Other intraoperative cardiac functional disturbances during cardiac surgery*
I97.791	*Other intraoperative cardiac functional disturbances during other surgery*
I97.88	*Other intraoperative complications of the circulatory system, not elsewhere classified*
I97.89	*Other postprocedural complications and disorders of the circulatory system, not elsewhere classified*

ICD-10 Diagnosis Code	***Definition***
M32.11	*Endocarditis in systemic lupus erythematosus*
R00.1	*Bradycardia, unspecified*
R57.0	*Cardiogenic shock*
T82.221A	*Breakdown (mechanical) of biological heart valve graft, initial encounter*
T82.222A	*Displacement of biological heart valve graft, initial encounter*
T82.223A	*Leakage of biological heart valve graft, initial encounter*
T82.228A	*Other mechanical complication of biological heart valve graft, initial encounter*
T82.512A	*Breakdown (mechanical) of artificial heart, initial encounter*
T82.514A	*Breakdown (mechanical) of infusion catheter, initial encounter*
T82.518A	*Breakdown (mechanical) of other cardiac and vascular devices and implants, initial encounter*
T82.522A	*Displacement of artificial heart, initial encounter*
T82.528A	*Displacement of other cardiac and vascular devices and implants, initial encounter*
T82.529A	*Displacement of unspecified cardiac and vascular devices and implants, initial encounter*
T82.532A	*Leakage of artificial heart, initial encounter*
T82.538A	*Leakage of other cardiac and vascular devices and implants, initial encounter*

T82.592A	*Other mechanical complication of artificial heart, initial encounter*
T82.598A	*Other mechanical complication of other cardiac and vascular devices and implants, initial encounter*
T86.20	*Unspecified complication of heart transplant*
T86.21	*Heart transplant rejection*
T86.22	*Heart transplant failure*
T86.23	*Heart transplant infection*
T86.290	*Cardiac allograft vasculopathy*
T86.298	*Other complications of heart transplant*
T86.30	*Unspecified complication of heart-lung transplant*
T86.31	*Heart-lung transplant rejection*
T86.32	*Heart-lung transplant failure*
T86.33	*Heart-lung transplant infection*
T86.39	*Other complications of heart-lung transplant*
Z48.21	*Encounter for aftercare following heart transplant*
Z48.280	*Encounter for aftercare following heart-lung transplant*
Z94.1	*Heart transplant status*
Z94.3	*Heart and lungs transplant status*
Z95.811	*Presence of heart assist device effective 12/01/20*

This policy does not address coverage of VADs for right ventricular support, biventricular support, use in beneficiaries under the age of 18, use in beneficiaries with complex congenital heart disease, or use in beneficiaries with acute heart failure without a history of chronic heart failure. Coverage under section 1862(a) (1) (A) of the Social Security Act for VADs in these situations will be made by local Medicare Administrative Contractors (MACs) within their respective jurisdictions.

400.2.2 - A/B MAC (A) Revenue Code

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

The following Revenue Codes are used for billing inpatient and outpatient CAR T-cell therapy services:
0871 – Cell Collection w/CPT code 0537T end date 12/31/24 and replaced with 38225 effective 01/01/25.
0872 – Specialized Biologic Processing and Storage – Prior to Transport w/CPT code 0538T end date 12/31/24 and replaced with 38226 effective 01/01/25.
0873 – Storage and Processing after Receipt of Cells from Manufacturer w/CPT code 0539T end date 12/31/24 and replaced with 38227 effective 01/01/25.
0874 – Infusion of Modified Cells w/CPT code 0540T end date 12/31/24 and replaced with 38228 effective 01/01/25.
0891 – Special Processed Drugs – FDA Approved Cell Therapy w/ Healthcare Common Procedure Coding System (HCPCS) codes:
Q2041, Q2042, C9073 (replaced with Q2053 *04/01/21*),
Q2058 for Obe-cel/AUCATZYL® effective 07/01/25,

C9076 (replaced with Q2054 *10/01/21*),
C9081 (replaced with Q2055 *01/01/22*),
C9098 (replaced with Q2056 *10/01/22*), or C9399.
C9301 for Obe-cel/AUCATZYL® effective 04/01/25 – 06/30/2025

400.2.3 - A/B MAC Billing HCPCS Codes

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

The following HCPCS/CPT procedure codes are used for billing outpatient CAR T-cell therapy services:
HCPCS Code Q2041 for Axicabtagene Ciloleucel
HCPCS Code Q2042 for Tisagenlecleucel
HCPCS Code Q2053 for Brexucabtagene Autoleucel (effective *04/01/21*)
HCPCS Code Q2054 for Lisocabtagene Maraleucel (effective *10/01/21*)
HCPCS Code Q2055 for Idecabtagene Vicleucel (effective *01/01/22*)
HCPCS Code Q2056 for Ciltacabtagene Autoleucel (effective *10/01/22*)
HCPCS Code Q2058 for Obe-cel/Aucatzyl (effective 07/01/25)
HCPCS Code C9073 for Brexucabtagene Autoleucel (prior to *04/01/21*)
HCPCS Code C9076 for Lisocabtagene maraleucel (prior to *10/01/21*)
HCPCS Code C9081 for Idecabtagene Vicleucel (prior to *01/01/22*)
HCPCS Code C9098 for Ciltacabtagene Autoleucel (prior to 10/01/22)
HCPCS Code C9301 for Obe-cel Aucatzyl) (effective 04/01/25 – 06/30/25)

HCPCS Code C9399, J3490, J3590, or J9999 for unclassified drugs or biologicals when dose of CAR T-cell therapy exceeds code descriptor or when other CAR T-cell therapy obtains FDA approval but has not yet received a specific HCPCS code
CPT Code 0537T collection/handling* end date 12/31/24 and replaced with 38225 effective 01/01/25.
CPT Code 0538T preparation for transport* end date 12/31/24 and replaced with 38226 effective 01/01/25.
CPT Code 0539T receipt and preparation* end date 12/31/24 and replaced with 38227 effective 01/01/25.
CPT Code 0540T the provider (physician/NPP) procedure to administer CAR T-cells end date 12/31/24 and replaced with 38228 effective 01/01/25.

* Procedure represents the various steps required to collect and prepare the genetically modified T-cells, and these steps are not paid separately under the Outpatient Prospective Payment System (OPPS)/Medicare Physician Fee Schedule (MPFS).

400.2.3.1 – A/B MAC (B) Places of Service (POS)

(Rev. 13549; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

The following places of service (POS) are covered for CAR T-cells product HCPCS codes (Q2041, Q2042, Q2053-Q2056, *Q2058,* J3490, J3590, and J9999):
11 (Office)
49 (Independent clinic)

Professional claims for the procedure to administer CAR T-cells (0540T) end date 12/31/24 and replaced with 38228 effective 01/01/25 may include (but are not necessarily limited to):
11 (Office)
19 (Off Campus-Outpatient Hospital)
21 (Inpatient Hospital)
22 (On Campus-Outpatient Hospital)
49 (Independent Clinic)