

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13709	Date: April 2, 2026
	Change Request 14430

SUBJECT: Update to the Internet Only Manual (IOM) Publication 100-04, Chapter 18, Section 170.1 and Chapter 32, sections 330.1 and 330.2 for Updates in Change Request (CR) 14356 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)- July 2026

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Publication (Pub.) 100-04, Chapter 18, Section 170.1, and Chapter 32, Sections 330.1 and 330.2 of the Medicare Claims Processing Manual to align with the National Coverage Determination (NCD) updates in CR 14356 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - July 2026.

EFFECTIVE DATE: June 2, 2026

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

IMPLEMENTATION DATE: June 2, 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	18/170/170.1/Healthcare Common Procedure Coding System (HCPCS) Codes for Screening for STIs and HIBC to Prevent STIs
R	32/330/330.1/Claims Processing Requirements for Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS) on Professional Claims
R	32/330/330.2/Claims Processing Requirements for PILD for Outpatient Facilities

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: 13709	Date: April 2, 2026	Change Request: 14430
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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, Section 170.1 and Chapter 32, Sections 330.1 and 330.2 of the Medicare Claims Processing Manual. The revisions listed below can be found in CR14356 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - July 2026.

* NCD 210.10 Screening STI and HIBC to Prevent STIs: Add CPT 87494 (used for combined chlamydia and gonorrhea testing) as a covered code for this policy effective January 1, 2026. (Pub. IOM 100-04 Chapter 18, Section 170.1)

* NCD 150.13 Percutaneous Image-Guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis: end date CPT code 0275T effective December 31, 2025, and add CPT code 62330 effective January 1, 2026. In addition, add POS 19 effective January 1, 2016. (Pub. IOM 100-04 Chapter 32, Sections 330.1 and 330.2)

B. Policy: N/A

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	
14430.1	Contractors shall be aware of the manual updates in IOM Pub. 100-04 Chapter 18, Section 170.1. Note: Add 87494 (used for combined chlamydia and gonorrhea testing) as a covered	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	code effective January 1, 2026)									
14430.2	Contractors shall be aware of the manual updates in IOM Pub. 100-04 Chapter 32, Sections 330.1 and 330.2. Note: End date CPT code 0275T effective December 31, 2025, and add CPT code 62330 effective January 1, 2026. In addition, add POS 19 effective January 1, 2016.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

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. 13709; Issued: 04-02-26)

[Transmittals for Chapter 18](#)

170.1 - Healthcare Common Procedure Coding System (HCPCS) Codes for Screening for STIs and HIBC to Prevent STIs

(Rev. 13709; Issued:04-02-26, Effective: 06-02-26; Implementation: 06-02-26)

Effective for claims with dates of service on and after November 8, 2011, the claims processing instructions for payment of screening tests for STI will apply to the following HCPCS/CPT codes:

- Chlamydia:
86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800,
87494 - effective 01/01/26 (used for combined chlamydia and gonorrhea testing),
0353U - effective 10/01/22 (used for combined chlamydia and gonorrhea testing),
0402U - effective 10/01/23 (used for combined chlamydia and gonorrhea testing),
0455U – effective 07/01/24 (used for combined chlamydia and gonorrhea testing)

- Gonorrhea:
87590, 87591, 87850, 87800,
87494 - effective 01/01/26 (used for combined chlamydia and gonorrhea testing),
0353U - effective 10/01/22 (used for combined chlamydia and gonorrhea testing),
0402U - effective 10/01/23 (used for combined chlamydia and gonorrhea testing),
0455U – effective 07/01/24 (used for combined chlamydia and gonorrhea testing)

- Syphilis: 86592, 86593, 86780
 - Hepatitis B: (hepatitis B surface antigen): 87340, 87341

Effective for claims with dates of service on and after November 8, 2011, implemented with January 2, 2012, IOCE, the following HCPCS code is to be billed for HIBC to prevent STIs:

- G0445 - high-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

Table of Contents
(Rev. 13709; Issued: 04-02-26)

[Transmittals for Chapter 32](#)

330.1 – Claims Processing Requirements for Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS) on Professional Claims

(Rev. 13709; Issued:04-02-26, Effective: 06-02-26; Implementation: 06-02-26)

For claims with dates of service on or after January 9, 2014, PILD (procedure code 0275T - *end date 12/31/25*) is a covered service when billed as part of a clinical trial approved by CMS.

The description for CPT 0275T *end date 12/31/25* is : “Percutaneous laminotomy/laminectomy (intradiscal approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy”, any method, under indirect image guidance (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar” .

CPT 62330 describes percutaneous image-guided lumbar decompression (PILD) for spinal stenosis, involving the removal of the ligamentum flavum and laminotomy, with imaging (CT or fluoroscopy) and epidurography.

Effective January 1, 2026, 62330 is replacing the former CPT code (0275T – end date effective 12/31/25).

For claims with dates of service on or after January 1, 2015, PILD (procedure code G0276) is a covered service when billed as part of a clinical trial approved by CMS. HCPCS G0276 is “Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD), or placebo control, performed in an approved coverage with evidence development (CED) clinical trial”.

Effective for dates of service on or after December 7, 2016, Medicare will cover PILD under CED for beneficiaries with LSS who are enrolled in a CMS-approved prospective longitudinal study for PILD procedures using a FDA-approved/cleared device that completed a CMS-approved randomized, controlled clinical trial (RCT) that met the criteria listed in the January 2014 NCD (see CR 8757, transmittal # 2959, dated May 16, 2014).

The claim may only contain one of these procedure codes, not both. To *report* G0276, the procedure must be performed within a *CMS approved* CED clinical trial that is randomized, blinded, and *includes* a placebo control arm of the trial. CMS will cover procedure code 0275T (*end date effective 12/31/25*) for PILD only when the procedure is performed within any other CED approved clinical trial. Regardless of the type of CED approved clinical trial (e.g. G0276 vs 0275T (*end date effective 12/31/25*)), PILD is only covered when billed for the ICD-9 diagnosis of 724.01-724.03 or the ICD-10 diagnosis of M48.05-M48.07, when billed in places of service *19 (Off Campus-Outpatient Hospital (effective 01/01/16))*, *22 (Outpatient)* or *24 (Ambulatory Surgical Center)*, when billed along with V70.7 (ICD-9) or Z00.6 (ICD-10) in either the primary/secondary positions, and when billed with modifier Q0.

Additionally, per Transmittal 2805 (Change Request 8401), issued October 30, 2013, all claims for clinical trials must contain the 8-digit clinical trial identifier number.

The following message(s) shall be used to notify providers of return situations that may occur:

Professional Claims 8-digit Clinical Trial Number

For PILD claims with procedure code 0275T (*end date 12/31/25*) with dates of service on or after January 9, 2014, or claims with procedure code G0276 with dates of service on or after January 1, 2015, contractors shall pay for PILD only when billed with the numeric, 8-digit clinical trial identifier number preceded by the two alpha characters "CT" when placed in Field 19 of paper Form CMS-1500, or when entered without the "CT" prefix in the electronic 837P in Loop 2300 REF02 (REF01=P4). Claims for PILD which are billed without an 8-digit clinical trial identifier number shall be returned as un-processable.

Note: Effective January 1, 2026, CPT 62330 is replacing the former CPT code (0275T – end date effective 12/31/25).

The following messages shall be used when Medicare contractors return PILD claims billed without an 8-digit clinical trial identifier number as un-processable:

Claims Adjustment Reason Code 16: "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication".

Remittance Advice Remark Code N721: "This service is only covered when performed as part of a clinical trial."

Remittance Advice Remark Code MA50: "Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number."

Remittance Advice Remark Code N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."

Professional Claims Place of Service – 19 (*effective 01/01/16*), 22 or 24 CMS

For PILD claims with procedure code *62330 effective 01/01/26* or for claims with procedure code G0276 with dates of service on or after January 1, 2015, contractors shall pay for PILD for LSS claims only when billed in place of service *19, 22* or 24. Claims for PILD which are billed in any other place of service shall be returned as un-processable.

The following messages shall be used when Medicare contractors return PILD claims not billed in place of service *19, 22* or 24:

Claims Adjustment Reason Code 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."

Remittance Advice Remark Code N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."

Professional Claims Modifier – Q0

For PILD claims with procedure code 0275T *has an end date 12/31/25*, with dates of service on or after January 9, 2014, (*note: 0275T is being replaced with 62330 effective 01/01/26*) or for claims with procedure code G0276 with dates of service on or after January 1, 2015, contractors shall pay for PILD for LSS claims only when billed with modifier Q0. Claims for PILD which are billed without modifier Q0 shall be returned as un-processable.

The following messages shall be used when Medicare contractors return PILD claims billed without modifier Q0 as un-processable:

Claims Adjustment Reason Code 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing.”

Remittance Advice Remark Code N657: “This should be billed with the appropriate code for these services.”

Remittance Advice Remark Code N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."

Non-covered Diagnosis

For PILD claims with procedure code 0275T *end date 12/31/25*, with dates of service on or after January 9, 2014 (*note: 0275T is being replaced with 62330 effective 01/01/26*), or for claims with procedure code G0276 with dates of service on or after January 1, 2015, contractors shall pay for PILD for LSS claims only when billed with the ICD-9 diagnosis of 724.01-724.03 or the ICD-10 diagnosis of M48.05-M48.07.

The following messages shall be used when Medicare contractors return PILD claims, billed without the covered diagnosis, as un-processable:

Claims Adjustment Reason Code B22: “This payment is adjusted based on the diagnosis.”

Remittance Advice Remark Code N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."

Clinical Trial Diagnosis

For PILD claims with procedure code 0275T and *end date 12/31/25* with dates of service on or after January 9, 2014, (*note 0275T is being replaced with 62330 effective 01/01/26*), or for claims with procedure code G0276 with dates of service on or after January 1, 2015, contractors shall pay for PILD only when billed with the ICD-9 diagnosis of V70.7 (ICD-9) or Z00.6 (ICD-10) in either the primary or secondary positions. The following messages shall be used when Medicare contractors return PILD claims, billed without the clinical trial diagnosis, as un-processable:

Claims Adjustment Reason Code B22: “This payment is adjusted based on the diagnosis.”

Remittance Advice Remark Code N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."

330.2 - Claims Processing Requirements for PILD for Outpatient Facilities *(Rev. 13709; Issued:04-02-26, Effective: 06-02-26; Implementation: 06-02-26)*

Hospital Outpatient facilities shall bill for percutaneous image-guided lumbar decompression (PILD) procedure code 0275T *end date 12/31/25* effective on or after January 9, 2014 (*note 0275T is being replaced with 62330 effective 01/01/26*), or procedure code G0276 effective on or after January 1, 2015, for lumbar spinal stenosis (LSS) on a 13X or 85X TOB. Refer to Section 69 of this chapter for further guidance on billing under CED.

Effective for dates of service on or after December 7, 2016, Medicare will cover PILD under CED for beneficiaries with LSS who are enrolled in a CMS-approved prospective longitudinal study for PILD procedures using a FDA-approved/cleared device that completed a CMS-approved randomized, controlled clinical trial (RCT) that met the criteria listed in the January 2014 NCD (see CR 8757, transmittal # 2959, dated May 16, 2014).

Hospital outpatient procedures for PILD shall be covered when billed with:

- ICD-9 V70.7 (ICD-10 Z00.6) and Condition Code 30.
- Modifier Q0
- An 8-digit clinical trial identifier number listed on the CMS Coverage with Evidence Development website

Hospital outpatient procedures for PILD shall be rejected when billed without:

- ICD-9 V70.7 (ICD-10 Z00.6) and Condition Code 30.
- Modifier Q0
- An 8-digit clinical trial identifier number listed on the CMS Coverage with Evidence Development website

Claims billed by hospitals not participating in the trial /registry, shall be rejected with the following message:

CARC: 50 -These are non-covered services because this is not deemed a “medical necessity” by the payer.

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 <http://www.cms.hhs.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 –Contractual Obligation (CO)

MSN 16.77 – This service/item was not covered because it was not provided as part of a qualifying trial/study. (Este servicio/artículo no fue cubierto porque no estaba incluido como parte de un ensayo clínico/estudio calificado.)