

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13809	Date: June 4, 2026
	Change Request 14463

SUBJECT: Update to the Internet Only Manual (IOM) Publication 100-04, Chapters 3, 13, 17, 18 and 32 for Coding Revisions to National Coverage Determination (NCDs) - January 2026 Change Requests (CRs) 14194 and 14197

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Publication (Pub.) 100-04, Chapter 3, Section 90.4.2, Chapter 13, Sections 30.1.3.1 and 60.16, Chapter 17, Section 80.2, Chapter 18, Sections 20.2, 30.6, 60, 250.1 and Chapter 32, Sections 11.3.2 and 260.1.1 of the Medicare Claims Processing Manual to coincide with the National Coverage Determination (NCD) updates in CRs 14194 and 14197, "International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to the National Coverage Determination (NCDs) - January 2026."

EFFECTIVE DATE: July 6, 2026

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

IMPLEMENTATION DATE: July 6, 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	3/90/90.4.2/Billing for Liver Transplant and Acquisition Services
R	13/30/30.1.3.1/A/B MAC (A) Payment for Low Osmolar Contrast Material (LOCM) (Radiology)
R	13/60/60.16/Billing and Coverage Changes for PET Scans Effective for Services on or After April 3, 2009
R	17/80/80.2/Oral Anti-Emetic Drugs Used as Full Replacement for Intravenous Anti-Emetic Drugs as Part of a Cancer Chemotherapeutic Regimen
R	18/20/20.2/HCPCS and Diagnosis Codes for Mammography Services
R	18/30/30.6/Screening Pap Smears: Diagnoses Codes
R	18/60/Colorectal Cancer Screening
R	18/250/250.1/Policy
R	32/11/11.3.2/Healthcare Common Procedure Coding System (HCPCS) Codes and Diagnosis Coding
R	32/260/260.1.1/Hospital Billing Instructions

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: 13809	Date: June 4, 2026	Change Request: 14463
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II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update the Publication (Pub.) 100-04, Chapter 3, Section 90.4.2, Chapter 13, Sections 30.1.3.1 and 60.16, Chapter 17, Section 80.2, Chapter 18, Sections 20.2, 30.6, 60, 250.1 and Chapter 32, Sections 11.3.2 and 260.1.1 of the Medicare Claims Processing Manual to coincide with the National Coverage Determination (NCD) updates in CRs 14194 and 14197, "International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to the National Coverage Determination (NCDs) - January 2026."

NCD 20.16 - Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB): Add ICD-10 CM codes I27.840, I27.841, I27.848, and I27.849 to the covered diagnosis code list effective October 1, 2025. (Pub. 100-04 Chapter 13, Section 30.1.3.1)

NCD 110.18 - Aprepitant for Chemotherapy Induced Emesis: Add ICD-10 diagnosis codes C50.A1 and C50.A2 effective October 1, 2025. (Pub. 100-04 Chapter 17, Section 80.2)

NCD 210.2 - Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer: Add ICD-10 diagnosis codes Z84.A and Z91.B to PAP High Risk and Pelvic Exam effective October 1, 2025 and add ICD-10 diagnosis codes R87.810 and R87.612 to PAP High Risk and Pelvic Exam effective October 1, 2015. (Pub. 100-04 Chapter 18, Section 30.6)

NCD 210.3 - Colorectal Cancer Screening Tests: Add ICD-10 CM codes Z15.060 and Z15.068 to list 1 effective October 1, 2025 and revise descriptor for ICD-10 CM code Z83.718 in list 1 effective October 1, 2025. (Pub. 100-04 Chapter 18, Section 60)

NCD 210.15 - Preexposure Prophylaxis (PrEP) Using Antiretroviral Therapy to Prevent Human Immunodeficiency Virus (HIV) Infection:

Add coverage for Yeztugo (Lenacapavir) HCPCS code J0738 for the injectable (Injection, lenacapavir, 1 mg, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV) effective October 1, 2025. (Pub. 100-04 Chapter 18, Section 250.1)

NCD 220.4 - Mammograms: Add ICD-10 diagnosis codes C50.A1, C50.A2, Z84.A, Z91.B effective October 1, 2025. (Pub. 100-04 Chapter 18, Section 20.2)

NCD 220.6.17 - PET for Oncologic Conditions: Add ICD-10 diagnosis codes C50.A1, C50.A2, Z85.4A effective October 1, 2025.(Pub. 100-04 Chapter 13, Section 60.16)

NCD 220.13 - Percutaneous Image Guided Breast Biopsy: Add ICD-10 diagnosis codes C50.A1, C50.A2 effective October 1, 2025.(Pub. 100-04 Chapter 18, Section 20.2)

NCD 250.5 Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS): End-date ICD10 diagnosis code E88.1 effective September 30, 2025, and add ICD-10 diagnosis code E88.14 effective October 1, 2025.(Pub. 100-04 Chapter 32, Section 260.1.1)

NCD 260.1 Adult Liver Transplantation: End-date ICD10 diagnosis code E72.53 effective September 30, 2025, and add ICD-10 diagnosis codes E72.530, I27.840 effective October 1, 2025.(Pub. 100-04 Chapter 3, Section 90.4.2)

NCD 270.1 Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds: Add ICD-10 diagnoses codes L98.432, L98.433, L98.434, L98.435, L98.436, L98.438, L98.442, L98.443, L98.444, L98.445, L98.446, L98.448, L98.452, L98.453, L98.454, L98.455, L98.456, L98.458, L98.462, L98.463, L98.464, L98.465, L98.466, L98.468, L98.472, L98.473, L98.474, L98.475, L98.476, L98.478, L98.A112, L98.A113, L98.A114, L98.A115, L98.A116, L98.A118, L98.A122, L98.A123, L98.A124, L98.A125, L98.A126, L98.A128, L98.A212, L98.A213, L98.A214, L98.A215, L98.A216, L98.A218, L98.A222, L98.A223, L98.A224, L98.A225, L98.A226, L98.A228, L98.A312, L98.A313, L98.A314, L98.A315, L98.A316, L98.A318, L98.A322, L98.A323, L98.A324, L98.A325, L98.A326, L98.A328 effective October 1, 2025.(Pub. 100-04 Chapter 32, Section 11.3.2)

NCD 270.3 Blood Derived Products for Chronic Nonhealing Wounds: Add ICD-10 diagnoses codes L98.431, L98.432, L98.433, L98.434, L98.435, L98.436, L98.438, L98.441, L98.442, L98.443, L98.444, L98.445, L98.446, L98.448, L98.451, L98.452, L98.453, L98.454, L98.455, L98.456, L98.458, L98.461, L98.462, L98.463, L98.464, L98.465, L98.466, L98.468, L98.471, L98.472, L98.473, L98.474, L98.475, L98.476, L98.478, L98.A111, L98.A112, L98.A113, L98.A114, L98.A115, L98.A116, L98.A118, L98.A121, L98.A122, L98.A123, L98.A124, L98.A125, L98.A126, L98.A128, L98.A211, L98.A212, L98.A213, L98.A214, L98.A215, L98.A216, L98.A218, L98.A221, L98.A222, L98.A223, L98.A224, L98.A225, L98.A226, L98.A228, L98.A311, L98.A312, L98.A313, L98.A314, L98.A315, L98.A316, L98.A318, L98.A321, L98.A322, L98.A323, L98.A324, L98.A325, L98.A326, L98.A328 effective October 1, 2025.(Pub. 100-04 Chapter 32, Section 11.3.2)

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	
14463.1	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 13, Section 30.1.3.1. Note: Add ICD-10 CM codes I27.840, I27.841, I27.848, and I27.849 to the covered diagnosis code list effective	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	October 1, 2025.									
14463.2	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 17, Section 80.2. Note: Add ICD-10 diagnosis codes C50.A1 and C50.A2 effective October 1, 2025.	X			X					
14463.3	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 18, Section 30.6. Note: Add ICD-10 diagnosis codes Z84.A and Z91.B to PAP High Risk and Pelvic Exam effective October 1, 2025 and add ICD-10 diagnosis codes R87.810 and R87.612 to PAP High Risk and Pelvic Exam effective October 1, 2015.	X	X							
14463.4	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 18, Section 60. Note: Add ICD-10 CM codes Z15.060 and Z15.068 to list 1 effective October 1, 2025 and revise descriptor for ICD-10 CM code Z83.718 in list 1 effective October 1, 2025.	X	X							
14463.5	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 18, Section 250.1. Note: Add coverage for Yeztugo (Lenacapavir) HCPCS code J0738 for the injectable (Injection, lenacapavir, 1 mg, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV) effective	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	October 1, 2025 and J0752 for the oral form (Oral, lenacapavair, 300 mg, FDA approved prescription, only for use as HIV- pre-exposure prophylaxis (not for use as treatment for HIV) effective October 1, 2025.									
14463.6	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 18, Section 20.2. Note: For Mammograms - Add ICD-10 diagnosis codes C50.A1, C50.A2, Z84.A, Z91.B effective October 1, 2025.	X	X							
14463.7	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 18, Section 20.2. Note: For Percutaneous Image Guided Breast Biopsy - Add ICD-10 diagnosis codes C50.A1 and C50.A2, effective October 1, 2025.	X	X							
14463.8	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 13, Section 60.16. Note: Add ICD-10 diagnosis codes C50.A1, C50.A2, Z85.4A effective October 1, 2025.	X	X							
14463.9	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 32, Section 260.1.1. Note: End-date ICD10 diagnosis code E88.1 effective September 30, 2025, and add ICD-10 diagnosis code E88.14	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	effective October 1, 2025.									
14463.10	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 3, Section 90.4.2. Note: End-date ICD10 diagnosis code E72.53 effective September 30, 2025, and add ICD-10 diagnosis codes E72.530, I27.840 effective October 1, 2025.	X	X							
14463.11	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 32, Section 11.3.2. Note: Add ICD-10 diagnoses codes L98.432, L98.433, L98.434, L98.435, L98.436, L98.438, L98.442, L98.443, L98.444, L98.445, L98.446, L98.448, L98.452, L98.453, L98.454, L98.455, L98.456, L98.458, L98.462, L98.463, L98.464, L98.465, L98.466, L98.468, L98.472, L98.473, L98.474, L98.475, L98.476, L98.478, L98.A112, L98.A113, L98.A114, L98.A115, L98.A116, L98.A118, L98.A122, L98.A123, L98.A124, L98.A125, L98.A126, L98.A128, L98.A212, L98.A213, L98.A214, L98.A215, L98.A216, L98.A218, L98.A222, L98.A223, L98.A224, L98.A225, L98.A226, L98.A228, L98.A312, L98.A313, L98.A314, L98.A315, L98.A316, L98.A318, L98.A322, L98.A323, L98.A324, L98.A325, L98.A326, L98.A328 effective October 1, 2025.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14463.12	Contractors shall be aware of the manual updates in Pub. 100-04 Chapter 32, Section 11.3.2. Note: Add ICD-10 diagnoses codes L98.431, L98.441, L98.451, L98.461, L98.471, L98.A111, L98.A121, L98.A211, L98.A221, L98.A311, L98.A321, effective October 1, 2025.	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 3 – Inpatient Hospital Billing

Table of Contents
(Rev. 13809; Issued: 06-04-26)

90.4.2 - Billing for Liver Transplant and Acquisition Services

(Rev.13809, Issued:06-04-26, Effective:07-06-26, Implementation:07-06-26)

The inpatient claim is completed in accordance with instructions in chapter 25 for the beneficiary who receives a covered liver transplant. Applicable standard liver acquisition charges are identified separately by revenue code 081X. Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charge for services furnished directly to the Medicare recipient.

The contractor deducts liver acquisition charges for IPPS hospitals prior to processing through Pricer. Costs of liver acquisition incurred by approved liver transplant facilities are not included in the liver transplant prospective payment. They are paid on a reasonable cost basis. This item is a "pass-through" cost for which interim payments are made. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes liver acquisition charges under revenue code 081X in the HUIP record that it sends to CWF and the QIO.

MCE Interface

The MCE contains a limited coverage edit for liver transplant procedures using below ICD-10-CM codes if ICD-10-CM is applicable.

Effective for services on or after September 30, 2025, end-date ICD-10 diagnosis code E72.53.

Effective for services on or after October 1, 2025, add ICD-10 diagnosis codes E72.530, I27.840.

Medicare Claims Processing Manual

Chapter 13 - Radiology Services and Other Diagnostic Procedures

Table of Contents
(Rev. 13809; Issued: 06-04-26)

30.1.3.1 - A/B MAC (A) Payment for Low Osmolar Contrast Material (LOCM) (Radiology)

(Rev.13809, Issued:06-04-26, Effective:07-06-26, Implementation:07-06-26)

The LOCM is paid on a reasonable cost basis when rendered by a SNF to its Part B patients (in addition to payment for the radiology procedure) when it is used in one of the situations listed below.

The following HCPCS are used when billing for LOCM.

HCPCS Code	Description (January 1, 1994, and later)
A4644	Supply of low osmolar contrast material (100-199 mgs of iodine);
A4645	Supply of low osmolar contrast material (200-299 mgs of iodine); or
A4646	Supply of low osmolar contrast material (300-399 mgs of iodine).

When billing for LOCM, SNFs use revenue code 0636. If the SNF charge for the radiology procedure includes a charge for contrast material, the SNF must adjust the charge for the radiology procedure to exclude any amount for the contrast material.

NOTE: LOCM is never billed with revenue code 0255 or as part of the radiology procedure.

The A/B MAC (A) will edit for the intrathecal procedure codes and the following codes to determine if payment for LOCM is to be made. If an intrathecal procedure code is not present, or one of the ICD codes is not present to indicate that a required medical condition is met, the A/B MAC (A) will deny payment for LOCM. In these instances, LOCM is not covered and should not be billed to Medicare.

When LOCM Is Separately Billable and Related Coding Requirements

- In all intrathecal injections. HCPCS codes that indicate intrathecal injections are:

70010 70015 72240 72255 72265 72270 72285 72295

One of these must be included on the claim; or

- In intravenous and intra-arterial injections only when certain medical conditions are present in an outpatient. The SNF must verify the existence of at least one of the following medical conditions, and report the applicable diagnosis code(s) either as a principal diagnosis code or other diagnosis codes on the claim:
 - A history of previous adverse reaction to contrast material. The applicable ICD-9-CM codes are V14.8 and V14.9. The applicable ICD-10-CM codes are Z88.8 and Z88.9. The conditions which should not be considered adverse reactions are a sensation of heat, flushing, or a single episode of nausea or vomiting. If the adverse reaction occurs on that visit with the induction of contrast material, codes describing hives, urticaria, etc. should also be present, as well as a code describing the external cause of injury and poisoning, ICD-9-CM code E947.8. The applicable ICD-10 CM codes are: T50.8X5A Adverse effect of diagnostic agents, initial encounter, T50.8X5S Adverse effect of diagnostic agents, sequela , T50.995A Adverse effect of other drugs, medicaments and biological substances, initial encounter, or T50.995S Adverse effect of other drugs, medicaments and biological substances, sequela;
 - A history or condition of asthma or allergy. The applicable ICD-9-CM codes are V07.1, V14.0 through V14.9, V15.0, 493.00, 493.01, 493.10, 493.11, 493.20, 493.21, 493.90, 493.91, 495.0, 495.1, 495.2, 495.3, 495.4, 495.5, 495.6, 495.7, 495.8, 495.9, 995.0, 995.1, 995.2, and 995.3. The applicable ICD-10-CM codes are in the table below:

ICD-10-CM Codes						
J44.0	J44.9	J45.20	J45.22	J45.30	J45.32	J45.40
J45.42	J45.50	J45.52	J45.902	J45.909	J45.998	J67.0
J67.1	JJ67.2	J67.3	J67.4	J67.5	J67.6	J67.7
J67.8	J67.9	J96.00	J96.01	J96.02	J96.90	J96.91
J96.92	T36.0X5A	T36.1X5A	T36.2X5A	T36.3X5A	T36.4X5A	T36.5X5A
T36.6X5A	T36.7X5A	T36.8X5A	T36.95XA	T37.0X5A	T37.1X5A	T37.2X5A
T37.3X5A	T37.8X5A	T37.95XA	T38.0X5A	T38.1X5A	T38.2X5A	T38.3X5A
T38.4X5A	T38.6X5A	T38.7X5A	T38.805A	T38.815A	T38.895A	T38.905A
T38.995A	T39.015A	T39.095A	T39.1X5A	T39.2X5A	T39.2X5A	T39.315A
T39.395A	T39.4X5A	T39.8X5A	T39.95XA	T40.0X5A	T40.1X5A	T40.2X5A
T40.3X5A	T40.4X5A	T40.5X5A	T40.605A	T40.695A	T40.7X5A	T40.8X5A
T40.905A	T40.995A	T41.0X5A	T41.1X5A	T41.205A	T41.295A	T41.3X5A
T41.4X5A	T41.X5A	T41.5X5A	T42.0X5A	T42.1X5A	T42.2X5A	T42.3X5A
T42.4X5A	T42.5X5A	T42.6X5A	427.5XA	428.X5A	T43.015A	T43.025A
T43.1X5A	T43.205A	T43.215A	T43.225A	T43.295A	T43.3X5A	T43.4X5A
T43.505A	T43.595A	T43.605A	T43.615A	T43.625A	T43.635A	T43.695A
T43.8X5A	T43.95XA	T44.0X5A	T44.1X5A	T44.2X5A	T44.3X5A	T44.6X5A
T44.7X5A	T44.8X5A	T44.905A	T44.995A	T45.0X5A	T45.1X5A	T45.2X5A
T45.3X5A	T45.4X5A	T45.515A	T45.525A	T45.605A	T45.615A	T45.625A
T45.695A	T45.7X5A	T45.8X5A	T45.95XA	T46.0X5A	T46.1X5A	T46.2X5A
T46.3X5A	T46.4X5A	T46.5X5A	T46.6X5A	T46.7X5A	T46.8X5A	T46.905A
T46.995A	T47.0X5A	T47.1X5A	T47.2X5A	T47.3X5A	T47.4X5A	T47.5X5A
T47.6X5A	T47.7X5A	T47.8X5A	T47.95XA	T48.0X5A	T48.1X5A	T48.205A
T48.295A	T48.3X5A	T48.4X5A	T48.5X5A	T48.6X5A	T48.905A	T48.995A
T49.0X5A	T49.1X5A	T49.2X5A	T49.3X5A	T49.4X5A	T49.5X5A	T49.6X5A
T49.6X5A	T47.X5A9	T49.8X5A	T49.95XA	T50.0X5A	T50.1X5A	T50.2X5A
T50.3X5A	T50.4X5A	T50.5X5A	T50.6X5A	T50.7X5A	T50.8X5A	T50.905a
T50.995A	T50.A15A	T50.A25A	T50.A95A	T50.B15A	T50.B95A	T50.Z15A
T50.Z95A	T78.2XXA	T78.3XXA	T78.40XA	T78.41XA	T88.52XA	T88.59XA
T88.6XXA	Z51.89	Z88.0	Z88.1	Z88.2	Z88.3	Z88.4
Z88.5	Z88.6	Z88.7	Z88.8	Z88.9	Z91.010	

- o Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension. The applicable ICD-9-CM codes are:

ICD-9-CM							
402.00	402.01	402.10	402.11	402.90	402.91		
404.00	404.01	404.02	404.03				
404.10	404.11	404.12	404.13				
404.90	404.91	404.92	404.93				
410.00	410.01	410.02	410.10	410.11	410.12		
410.20	410.21	410.22	410.30	410.31	410.32		
410.40	410.41	410.42	410.50	410.51	410.52		
410.60	410.61	410.62	410.70	410.71	410.72		
410.80	410.81	410.82	410.90	410.91	410.92		
411.1	415.0	416.0	416.1	416.8	416.9		
420.0	420.90	420.91	420.99	424.90	424.91		
424.99	427.0	427.1	427.2	427.31	427.32		
427.41	427.42	427.5	427.60	427.61	427.69		
427.81	427.89	427.9	428.0	428.1	428.9	429.0	

ICD-9-CM							
429.1	429.2	429.3	429.4	429.5	429.6	429.71	
429.79	429.81	429.82	429.89	429.9	785.50	785.51	785.59

- The applicable ICD-10-CM codes are in the table below:

ICD-10-CM Codes						
A18.84	I11.0	I11.9	I13.0	I13.10	I13.11	I13.2
I20.0	I21.01	I21.02	I21.09	I21.11	I21.19	I21.21
I21.29	I21.3	I21.4	I22.1	I22.2	I22.8	I23.0
I23.1	I23.2	I23.3	I23.4	I23.5	I23.6	I23.7
I23.8	I25.10	I25.110	I25.700	I25.710	I25.720	I25.730
I25.750	I25.760	I25.790	I26.01	I26.02	I26.09	I27.0
I27.1	I27.2	I27.81	I27.89	I27.9	I30.0	I30.1
I30.8	I30.9	I32	I38	I39	I46.2	I46.8
I46.9	I47.0	I471	I472	I47.9	I48.0	I48.1
I48.1	I48.2	I48.3	I48.4	I48.91	I48.92	I49.01
I49.02	I49.1	I49.2	I49.3	I49.40	I49.49	I49.5
I49.8	I49.9	I50.1	I50.20	I50.21	I50.22	I50.23
I50.30	I50.31	I50.32	I50.33	I50.40	I50.41	I50.42
I50.43	I50.9	I51	I51.0	I51.1	I51.2	I51.3
I51.4	I51.5	I51.7	I51.89	I51.9	I52	I97.0
I97.110	I97.111	I97.120	I97.121	I97.130	I97.131	I97.190
I97.191	M32.11	M32.12	R00.1	R57.0	R57.8	R57.9

- Generalized severe debilitation. The applicable ICD-9-CM codes are: 203.00, 203.01, all codes for diabetes mellitus, 518.81, 585, 586, 799.3, 799.4, and V46.1. The applicable ICD-10-CM codes are: J96.850, J96.00 through J96.02, J96.90 through J96.91, N18.1 through N19, R53.81, R64, and Z99.11 through Z99.12. Or
- Sickle Cell disease. The applicable ICD-9-CM codes are 282.4, 282.60, 282.61, 282.62, 282.63, and 282.69. The applicable ICD-10-CM codes are D56.0 through D56.3, D56.5 through D56.9, D57.00 through D57.1, D57.20, D57.411 through D57.419, and D57.811 through D57.819.

Effective for services on or after October 1, 2025 add ICD-10 CM codes I27.840, I27.841, I27.848, and I27.849 to the covered diagnosis code list.

60.16 - Billing and Coverage Changes for PET Scans Effective for Services on or After April 3, 2009

(Rev.13809, Issued:06-04-26, Effective:07-06-26, Implementation:07-06-26)

A. Summary of Changes

Effective for services on or after April 3, 2009, Medicare will **not cover** the use of FDG PET imaging to determine **initial treatment strategy** in patients with adenocarcinoma of the prostate.

Medicare will also not cover FDG PET imaging for **subsequent treatment strategy** for tumor types other than breast, cervical, colorectal, esophagus, head and neck (non-CNS/thyroid), lymphoma, melanoma, myeloma, non-small cell lung, and ovarian, unless the FDG PET is provided under the coverage with evidence development (CED) paradigm (billed with modifier -Q0/-Q1, see section 60.15 of this chapter).

Medicare will cover FDG PET imaging **for initial treatment strategy** for myeloma.

Effective for services performed on or after June 11, 2013, Medicare has ended the CED requirement for FDG PET and PET/CT and PET/MRI for all oncologic indications contained in section 220.6.17 of the NCD Manual. Effective for services on or after June 11, 2013, the Q0/Q1 modifier is no longer required.

Beginning with services performed on or after June 11, 2013, contractors shall pay for up to three (3) FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy (modifier PS) after completion of initial anti-cancer therapy (modifier PI) for the exact same cancer diagnosis.

Coverage of any additional FDG PET scans (that is, beyond 3) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-tumor therapy for the same cancer diagnosis will be determined by the A/B MACs (A or B). Claims will include the KX modifier indicating the coverage criteria is met for coverage of four or more FDG PET scans for subsequent treatment strategy for the same cancer diagnosis under this NCD.

A different cancer diagnosis whether submitted with a PI or a PS modifier will begin the count of one initial and three subsequent FDG PET scans not requiring the KX modifier and four or more FDG PET scans for subsequent treatment strategy for the same cancer diagnosis requiring the KX modifier.

Effective for services on or after October 1, 2025 add ICD-10 diagnosis codes C50.A1, C50.A2, and Z85.4A.

NOTE: The presence or absence of an initial treatment strategy claim in a beneficiary's record does not impact the frequency criteria for subsequent treatment strategy claims for the same cancer diagnosis.

NOTE: Providers please refer to the following link for a list of appropriate diagnosis codes, http://cms.gov/medicare/coverage/determinationprocess/downloads/petforsolidtumorsoncologicdxcodesattachment_NCD220_6_17.pdf

For further information regarding the changes in coverage, refer to Pub.100-03, NCD Manual, section 220.6.17.

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Chapter 17 – Drugs and Biologicals

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80.2 - Oral Anti-Emetic Drugs Used as Full Replacement for Intravenous Anti-Emetic Drugs as Part of a Cancer Chemotherapeutic Regimen

(Rev.13809, Issued:06-04-26, Effective:07-06-26, Implementation:07-06-26)

See the Medicare Benefit Policy Manual, Chapter 15, and the National Coverage Determination (NCD) Manual, Section 110.18, for detailed coverage requirements.

Effective for dates of service on or after January 1, 1998, Medicare Part B (including institutional claims processed by A/B MACs (A) and physician/supplier claims processed by DME MACs) pays for oral anti-emetic drugs when used as full therapeutic replacement for intravenous dosage forms as part of a cancer chemotherapeutic regimen when the drug(s) is administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent.

The allowable period of covered therapy includes day 1, the date of service of the chemotherapy drug (beginning at the time of treatment), plus a period not to exceed 2 additional calendar days, or a maximum period up to 48 hours. Some drugs are limited to 24 hours; some to 48 hours. The hour limit is included in the narrative description of the Health Care Common Procedure Coding System (HCPCS) code.

The oral, 3-drug combination is aprepitant, a 5HT₃ antagonist, e.g. granisetron, ondansetron, or dolasetron, and dexamethasone, a corticosteroid.

The oral anti-emetic drug(s) should be prescribed only on a per chemotherapy treatment basis. For example, only enough of the oral anti-emetic(s) for one 24- or 48-hour dosage regimen (depending upon the drug) should be prescribed/supplied for each incidence of chemotherapy treatment. The 3-drug combination protocol requires the first dose to be administered before, during, or immediately after the anti-cancer chemotherapy administration. The second day is defined as “within 24 hours” and the third day is defined as “within 48 hours” of the chemotherapy administration. These drugs may be supplied by the physician in the office, by an inpatient or outpatient provider (e.g., hospital, critical access hospital (CAH), skilled nursing facility (SNF), or through a supplier (e.g., a pharmacy).

The physician must indicate on the prescription that the beneficiary is receiving the oral anti-emetic drug(s) as a full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen. Where the drug is provided by a facility, the beneficiary’s medical record maintained by the facility must be documented to reflect that the beneficiary is receiving the oral anti-emetic drug(s) as full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen. All other indications or combinations for the use of oral aprepitant that are not noted in the NCD Manual Pub. 100-03 chapter 1, section 110.18, are non-covered under Medicare Part B, but may be considered for payment under Medicare Part D.

Payment for drugs used as a full replacement for intravenous anti-emetic drugs is made under Part B. Beginning January 1, 2005, the payment allowance limit for these Part B drugs (the term “drugs” includes biologicals) will be based on the Average Sales Price (ASP) plus 6%. Hospital outpatient department providers may either:

(1) Bill all doses of the 3-drug oral regimen that will be given in a 3-day period, including the entire Tri-Pak (3 days of aprepitant, 57 units of J8501) as well as the oral dexamethasone and oral 5HT₃ antagonist to the A/B MAC (A), or (2) Bill the first day’s supply of aprepitant along with an oral 5HT₃ antagonist and oral dexamethasone to their A/B MAC (A), and give a prescription for remaining doses of the regimen, for example the second and third days’ supply of aprepitant and oral dexamethasone, which must be billed to the DME MAC.

When billed to the A/B MAC (A), all three drugs in the combination oral anti-emetic must be on the same claim. Providers subject to the hospital outpatient PPS will be paid on the basis of an APC. If the hospital outpatient department dispenses the aprepitant for days two and three to the beneficiary and bills the DME

MAC for the take home drugs, the hospital's billing department should review all instructions for billing oral anti-emetics. Follow this link to reach the local coverage determination (LCD) for oral anti-emetics:

http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=5058&lcd_version=27&show=all

In the case of IV Emend (HCPCS code J1453 - injection, fosaprepitant, 1 mg) provided on day 1, payment for days 2 and 3 would not be made under Part B.

Payment allowances for these drugs dispensed in physician offices will be based on the lower of the submitted charge or the ASP file price. These drugs continue to be priced based on the date of service. The drug payment allowance limit pricing file is distributed to contractors by the Centers for Medicare & Medicaid Services (CMS) on a quarterly basis.

The HCPCS codes shown in section 80.2.1 are used.

The common working file (CWF) edits claims with these codes to assure that the beneficiary is receiving the oral anti-emetic(s) as part of a cancer chemotherapeutic regimen by requiring a diagnosis code of an encounter for antineoplastic chemotherapy (V58.11/Z51.11).

Most drugs furnished as an outpatient hospital service are packaged under OPPTS. However, chemotherapeutic agents and the supportive and adjunctive drugs used with them are paid separately.

Effective for dates of service on or after April 4, 2005, coverage for the use of the oral anti-emetic 3-drug combination of aprepitant (Emend®), a 5-HT₃ antagonist, and dexamethasone is considered reasonable and necessary for only those patients who are receiving one or more of the following anti-cancer chemotherapeutic agents:

- Carmustine
- Cisplatin
- Cyclophosphamide
- Dacarbazine
- Mechlorethamine
- Streptozocin
- Doxorubicin
- Epirubicin
- Lomustine

Effective for services on or after May 29, 2013, the following anti-cancer chemotherapeutic agents have been added to the list of anticancer chemotherapeutic agents for which the use of the oral antiemetic 3-drug combination of oral aprepitant, an oral 5HT₃ antagonist and oral dexamethasone is deemed reasonable and necessary:

- Alemtuzumab
- Azacitidine
- Bendamustine
- Carboplatin
- Clofarabine
- Cytarabine
- Daunorubicin
- Idarubicin
- Ifosfamide
- Irinotecan
- Oxaliplatin

MACs may determine coverage for other all-oral 3-drug anti-emesis regimens of aprepitant or any other Food and Drug Administration (FDA) approved oral NK-1 antagonist in combination with an oral 5HT₃ antagonist and oral dexamethasone with the chemotherapeutic agents listed above, or any other anti-cancer chemotherapeutic agents that are FD- approved and are defined as highly or moderately emetogenic. See the Medicare NCD Manual, Section 110.18, for detailed coverage requirements.

Effective for services on or after October 1, 2025 add ICD-10 diagnosis codes C50.A1 and C50.A2.

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Chapter 18 - Preventive and Screening Services

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(Rev. 13809; Issued: 06-04-26)

20.2 - HCPCS and Diagnosis Codes for Mammography Services

(Rev.13809, Issued:06-04-26, Effective:07-06-26, Implementation:07-06-26)

A. Diagnosis for Services On or After Oct 1, 2015

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-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 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 code 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.

ICD-10-CM Codes for a diagnostic mammography:

ICD-10 CM code	Definitions
C43.52	Malignant melanoma of skin of breast
C43.59	Malignant melanoma of other part of trunk
C44.511	Basal cell carcinoma of skin of breast
C44.519	Basal cell carcinoma of skin of other part of trunk
C44.521	Squamous cell carcinoma of skin of breast
C44.529	Squamous cell carcinoma of skin of other part of trunk
C44.591	Other specified malignant neoplasm of skin of breast
C44.599	Other specified malignant neoplasm of skin of other part of trunk
C45.9	Mesothelioma, unspecified
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.021	Malignant neoplasm of nipple and areola, right male breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast

C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
<i>C50.A1</i>	<i>Malignant inflammatory neoplasm of right breast (Effective 10/1/25)</i>
<i>C50.A2</i>	<i>Malignant inflammatory neoplasm of left breast (Effective 10/1/25)</i>
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C77.3	Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.40	Secondary malignant neoplasm of unspecified part of nervous system
C79.49	Secondary malignant neoplasm of other parts of nervous system
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.61	Secondary malignant neoplasm of right ovary
C79.62	Secondary malignant neoplasm of left ovary
C79.81	Secondary malignant neoplasm of breast
C80.0	Disseminated malignant neoplasm, unspecified
C80.1	Malignant (primary) neoplasm, unspecified
C84.7A	Anaplastic large cell lymphoma, ALK-negative, breast
D03.52	Melanoma in situ of breast (skin) (soft tissue)
D03.59	Melanoma in situ of other part of trunk
D04.5	Carcinoma in situ of skin of trunk
D05.01	Lobular carcinoma in situ of right breast
D05.02	Lobular carcinoma in situ of left breast
D05.11	Intraductal carcinoma in situ of right breast
D05.12	Intraductal carcinoma in situ of left breast
D05.81	Other specified type of carcinoma in situ of right breast
D05.82	Other specified type of carcinoma in situ of left breast
D22.5	Melanocytic nevi of trunk
D23.5	Other benign neoplasm of skin of trunk
D24.1	Benign neoplasm of right breast
D24.2	Benign neoplasm of left breast
D48.5	Neoplasm of uncertain behavior of skin
D48.61	Neoplasm of uncertain behavior of right breast

D48.62	Neoplasm of uncertain behavior of left breast
D49.1	Neoplasm of unspecified behavior of respiratory system
D49.6	Neoplasm of unspecified behavior of brain
D49.7	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
I80.8	Phlebitis and thrombophlebitis of other sites
M70.80	Other soft tissue disorders related to use, overuse and pressure of unspecified site
M70.88	Other soft tissue disorders related to use, overuse and pressure other site
M70.89	Other soft tissue disorders related to use, overuse and pressure multiple sites
M79.5	Residual foreign body in soft tissue
M79.81	Nontraumatic hematoma of soft tissue
M79.89	Other specified soft tissue disorders
N60.01	Solitary cyst of right breast
N60.02	Solitary cyst of left breast
N60.11	Diffuse cystic mastopathy of right breast
N60.12	Diffuse cystic mastopathy of left breast
N60.21	Fibroadenosis of right breast
N60.22	Fibroadenosis of left breast
N60.31	Fibrosclerosis of right breast
N60.32	Fibrosclerosis of left breast
N60.41	Mammary duct ectasia of right breast
N60.42	Mammary duct ectasia of left breast
N60.81	Other benign mammary dysplasias of right breast
N60.82	Other benign mammary dysplasias of left breast
N61.0	Mastitis without abscess
N61.1	Abscess of the breast and nipple
N61.21	Granulomatous mastitis, right breast
N61.22	Granulomatous mastitis, left breast
N61.23	Granulomatous mastitis, bilateral breast
N62	Hypertrophy of breast
N63.11	Unspecified lump in right breast, upper outer quadrant
N63.12	Unspecified lump in right breast, upper inner quadrant
N63.13	Unspecified lump in right breast, lower outer quadrant
N63.14	Unspecified lump in right breast, lower inner quadrant
N63.15	Unspecified lump in right breast, overlapping quadrants
N63.21	Unspecified lump in the left breast, upper outer quadrant
N63.22	Unspecified lump in left breast, upper inner quadrant
N63.23	Unspecified lump in left breast, lower outer quadrant
N63.24	Unspecified lump in left breast, lower inner quadrant
N63.25	Unspecified lump in left breast, overlapping quadrants
N63.31	Unspecified lump in axillary tail of the right breast
N63.32	Unspecified lump in axillary tail of the left breast
N63.41	Unspecified lump in right breast, subareolar
N63.42	Unspecified lump in left breast, subareolar
N64.0	Fissure and fistula of nipple
N64.1	Fat necrosis of breast
N64.2	Atrophy of breast
N64.3	Galactorrhea not associated with childbirth
N64.4	Mastodynia
N64.51	Induration of breast
N64.52	Nipple discharge
N64.53	Retraction of nipple
N64.59	Other signs and symptoms in breast

N64.81	Ptosis of breast
N64.82	Hypoplasia of breast
N64.89	Other specified disorders of breast
N64.9	Disorder of breast, unspecified
N65.0	Deformity of reconstructed breast
N65.1	Disproportion of reconstructed breast
R59.0	Localized enlarged lymph nodes
R59.1	Generalized enlarged lymph nodes
R59.9	Enlarged lymph nodes, unspecified
R92.0	Mammographic microcalcification found on diagnostic imaging of breast
R92.1	Mammographic calcification found on diagnostic imaging of breast
R92.2	Inconclusive mammogram
R92.30	Dense breasts, unspecified
R92.311	Mammographic fatty tissue density, right breast
R92.312	Mammographic fatty tissue density, left breast
R92.313	Mammographic fatty tissue density, bilateral breasts
R92.321	Mammographic fibroglandular density, right breast
R92.322	Mammographic fibroglandular density, left breast
R92.323	Mammographic fibroglandular density, bilateral breasts
R92.331	Mammographic heterogeneous density, right breast
R92.332	Mammographic heterogeneous density, left breast
R92.333	Mammographic heterogeneous density, bilateral breasts
R92.341	Mammographic extreme density, right breast
R92.342	Mammographic extreme density, left breast
R92.343	Mammographic extreme density, bilateral breasts
R92.8	Other abnormal and inconclusive findings on diagnostic imaging of breast
R93.9	Diagnostic imaging inconclusive due to excess body fat of patient
S20.01xA	Contusion of right breast, initial encounter
S20.02xA	Contusion of left breast, initial encounter
S21.011A	Laceration without foreign body of right breast, initial encounter
S21.012A	Laceration without foreign body of left breast, initial encounter
S21.021A	Laceration with foreign body of right breast, initial encounter
S21.022A	Laceration with foreign body of left breast, initial encounter
S21.031A	Puncture wound without foreign body of right breast, initial encounter
S21.032A	Puncture wound without foreign body of left breast, initial encounter
S21.041A	Puncture wound with foreign body of right breast, initial encounter
S21.042A	Puncture wound with foreign body of left breast, initial encounter
S21.051A	Open bite of right breast, initial encounter
S21.052A	Open bite of left breast, initial encounter
S28.211A	Complete traumatic amputation of right breast, initial encounter
S28.212A	Complete traumatic amputation of left breast, initial encounter
S28.221A	Partial traumatic amputation of right breast, initial encounter
S28.222A	Partial traumatic amputation of left breast, initial encounter
S29.091A	Other injury of muscle and tendon of front wall of thorax, initial encounter
S29.099A	Other injury of muscle and tendon of unspecified wall of thorax, initial encounter
S29.8xxA	Other specified injuries of thorax, initial encounter
S39.091A	Other injury of muscle, fascia and tendon of abdomen, initial encounter
S39.81xA	Other specified injuries of abdomen, initial encounter
T85.41xA	Breakdown (mechanical) of breast prosthesis and implant, initial encounter
T85.42xA	Displacement of breast prosthesis and implant, initial encounter
T85.43xA	Leakage of breast prosthesis and implant, initial encounter
T85.44xA	Capsular contracture of breast implant, initial encounter
T85.49xA	Other mechanical complication of breast prosthesis and implant, initial encounter

T85.79xA	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z77.123	Contact with and (suspected) exposure to radon and other naturally occurring radiation
Z77.128	Contact with and (suspected) exposure to other hazards in the physical environment
Z77.9	Other contact with and (suspected) exposures hazardous to health
<i>Z84.A</i>	<i>Family history of exposure to diethylstilbestrol (Effective 10/1/25)</i>
Z85.3	Personal history of malignant neoplasm of breast
Z85.831	Personal history of malignant neoplasm of soft tissue
Z85.89	Personal history of malignant neoplasm of other organs and systems
Z86.000	Personal history of in-situ neoplasm of breast
Z91.89	Other specified personal risk factors, not elsewhere classified
<i>Z91.B</i>	<i>Personal risk factor of exposure to diethylstilbestrol (Effective 10/1/25)</i>
Z92.89	Personal history of other medical treatment
Z98.82	Breast implant status
Z98.86	Personal history of breast implant removal

30.6 - Screening Pap Smears: Diagnoses Codes

(Rev.13809, Issued:06-04-26, Effective:07-06-26, Implementation:07-06-26)

Effective October 1, 2015 the below are the current diagnoses that should be used when billing for screening Pap smear services

The following chart lists the diagnosis codes that CWF must recognize for high-risk patients for every year screening Pap smear services.

ICD-10-CM Codes for PAP High Risk every year

ICD-10 CM code	Definitions
<i>R87.612</i>	<i>Low grade squamous intraepithelial lesion on cytologic smear of cervix (LGSIL) (Effective 10/1/15)</i>
<i>R87.810</i>	<i>Cervical high risk human papillomavirus (HPV) DNA test positive (Effective 10/1/15)</i>
Z77.29	Contact with and (suspected) exposure to other hazardous substances
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior
Z77.9	Other contact with and (suspected) exposures hazardous to health
<i>Z84.A</i>	<i>Family history of exposure to diethylstilbestrol (Effective 10/1/25)</i>
Z91.89	Other specified personal risk factors, not elsewhere classified
<i>Z91.B</i>	<i>Personal risk factor of exposure to diethylstilbestrol (Effective 10/1/25)</i>
Z92.850	Personal history of Chimeric Antigen Receptor T-cell therapy
Z92.858	Personal history of other cellular therapy
Z92.86	Personal history of gene therapy
Z92.89	Personal history of other medical treatment

The following chart lists the diagnosis codes that CWF must recognize for low-risk for every 2 years

ICD-10-CM Codes for PAP Low Risk every 2 years

ICD-10 CM code	Definitions
Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Z12.4	Encounter for screening for malignant neoplasm of cervix
Z12.72	Encounter for screening for malignant neoplasm of vagina
Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Z12.89	Encounter for screening for malignant neoplasm of other sites

A. Screening Pap Smears: Applicable Diagnoses for Billing A/B MAC (B)

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. Those diagnoses can be listed in Item 21 of Form CMS-1500 or the electronic equivalent (see Chapter 26 for electronic equivalent formats). In addition, one of the following diagnoses shall appear on the claim: the low-risk diagnosis of Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89 or the high-risk diagnosis of, *R87.612, R87.810 (effective 10/1/15), Z77.29, Z72.51, Z72.52, Z72.53, Z77.9, Z84.A (effective 10/1/25), Z91.89, Z91.B (effective 10/1/25), Z92.850, Z92.858, Z92.86, and Z92.89.* (Effective Oct 1, 2015) One of the above diagnoses must be listed in item 21 of the Form CMS-1500 or the electronic equivalent to indicate either low risk or high risk depending on the patient's condition. Then either the low-risk or high-risk diagnosis must also be pointed to in Item 24E of Form CMS-1500 or the electronic equivalent. Providers must make sure that for screening Pap smears for a high-risk beneficiary that the high-risk diagnosis code appears in Item 21 that must be pointed to in Item 24E or the electronic equivalent. If Pap smear claims do not point to one of these specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. **Periodically, A/B MACs (B) should do provider education on diagnosis coding of Pap smear claims.**

60 - Colorectal Cancer Screening

(Rev.13809, Issued:06-04-26, Effective:07-06-26, Implementation:07-06-26)

See the Medicare Benefit Policy Manual, Chapter 15, and the Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Section 210.3 for Medicare Part B coverage requirements and effective dates of colorectal cancer screening services.

Effective for services furnished on or after January 1, 1998, payment may be made for colorectal cancer screening for the early detection of cancer. For screening colonoscopy services (one of the types of services included in this benefit) prior to July 2001, coverage was limited to high-risk individuals. For services July 1, 2001, and later, screening colonoscopies are covered for individuals not at high risk.

The following services are considered colorectal cancer screening services:

- Fecal-occult blood test (FOBT), 1-3 simultaneous determinations (guaiac-based);
- Flexible sigmoidoscopy;
- Colonoscopy; and,
- Barium enema

Effective for services on or after January 1, 2004, payment may be made for the following colorectal cancer screening service as an alternative for the guaiac-based FOBT, 1-3 simultaneous determinations:

- FOBT, immunoassay, 1-3 simultaneous determinations

Effective for services on or after October 9, 2014, payment may be made for colorectal cancer screening using the Cologuard™ multi-target sDNA test:

- HCPCS G0464 (Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3).

Note: HCPCS code G0464 expired on December 31, 2015, and has been replaced in the 2016 CLFS with CPT code 81528, Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result, effective January 2, 2016.

Effective for services on or after January 19, 2021, payment may be made for colorectal cancer using Blood-based DNA Testing:

- Blood-based Biomarker Test, HCPCS G0327, effective July 1, 2021

Effective for services on or after October 1, 2025 add ICD-10 CM codes Z15.060 and Z15.068 to list 1 and revise descriptor for ICD-10 CM code Z83.718 in list 1.

250.1 Policy

(Rev.13809, Issued:06-04-26, Effective:07-06-26, Implementation:07-06-26)

The Centers for Medicare & Medicaid Services (CMS) has determined that Pre-Exposure Prophylaxis (PrEP) using antiretroviral drugs to prevent Human Immunodeficiency Virus (HIV) is covered as an additional preventive service under §1861(ddd)(1) of the Social Security Act (the Act).

Effective September 30, 2024, CMS covers PrEP using antiretroviral drugs approved by the U.S. Food and Drug Administration (FDA) to prevent HIV in individuals at increased risk of HIV acquisition. The determination of whether an individual is at increased risk for HIV is made by the physician or health care practitioner who assesses the individual's history. CMS also covers furnishing HIV PrEP using antiretroviral drugs, including the supplying or dispensing of these drugs and the administration of injectable PrEP.

For individuals being assessed for or using PrEP to prevent HIV, CMS covers all the following as an additional preventive service:

- Up to eight individual counseling visits, every 12 months, that include HIV risk assessment (initial or continued assessment of risk), HIV risk reduction, and medication adherence. Counseling must be furnished by a physician or other health care practitioner. Individuals must be competent and alert at the time that counseling is provided.
- Up to eight HIV screening tests every 12 months.
- A single screening for hepatitis B virus (HBV).

These screening tests are covered when the appropriate FDA-approved laboratory tests and point of care tests are used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations.

Effective services on or after October 1, 2025, coverage for Yeztugo (Lenacapavir) HCPCS code J0738 for the injectable (Injection, lenacapavir, 1 mg, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV) and J0752 for the oral form (Oral, lenacapavir, 300 mg, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV).

New PrEP drug codes J0738 (injectable) and J0752 (oral) are billable and adjudicated under the same conditions as existing PrEP injectable and oral drug codes (i.e., allowed ICD-10 codes, supply code requirements, TOBs, etc.).

Further information, including coverage guidelines can be found in Publication 100-03, Section 210.15.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

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(Rev. 13809; Issued: 06-04-26)

11.3.2 – Healthcare Common Procedure Coding System (HCPCS) Codes and Diagnosis Coding

(Rev.13809, Issued:06-04-26, Effective:07-06-26, Implementation:07-06-26)

Healthcare Common Procedure Coding System (HCPCS) Code

Effective for claims with dates of service on or after April 13, 2021, Medicare providers shall report HCPCS code G0460 for PRP services for the treatment of chronic non-healing non-diabetic wounds.

Effective for claims with dates of service on or after April 13, 2021, Medicare providers shall report HCPCS code G0465 for PRP services for the treatment of chronic non-healing diabetic wounds under the conditions and criteria outlined in NCD Manual Section 270.3.

If ICD-10 Diagnosis coding is applicable

For claims with dates of service on or after April 13, 2021, PRP, for the treatment of chronic non-healing diabetic wounds must be billed reporting both an ICD-10 diagnosis code for diabetes mellitus and an ICD-10 diagnosis code for chronic ulcers.

- Two diagnosis codes are required- Diabetic Mellitus plus Chronic Ulcer

Diabetes Mellitus

E08.621	Diabetes mellitus due to underlying condition with foot ulcer
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer
E09.622	Drug or chemical induced diabetes mellitus with other skin ulcer
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.622	Type 1 diabetes mellitus with other skin ulcer
E11.621	Type 2 diabetes mellitus with foot ulcer
E11.622	Type 2 diabetes mellitus with other skin ulcer
E13.621	Other specified diabetes mellitus with foot ulcer
E13.622	Other specified diabetes mellitus with other skin ulcer

Chronic Ulcer

L97.111	Non-pressure chronic ulcer of right thigh limited to breakdown of skin
L97.112	Non-pressure chronic ulcer of right thigh with fat layer exposed
L97.113	Non-pressure chronic ulcer of right thigh with necrosis of muscle
L97.115	Non-pressure chronic ulcer of right thigh with muscle involvement without evidence of necrosis
L97.116	Non-pressure chronic ulcer of right thigh with bone involvement without evidence of necrosis
L97.118	Non-pressure chronic ulcer of right thigh with other specified severity
L97.114	Non-pressure chronic ulcer of right thigh with necrosis of bone
L97.121	Non-pressure chronic ulcer of left thigh limited to breakdown of skin
L97.122	Non-pressure chronic ulcer of left thigh with fat layer exposed
L97.123	Non-pressure chronic ulcer of left thigh with necrosis of muscle
L97.124	Non-pressure chronic ulcer of left thigh with necrosis of bone
L97.125	Non-pressure chronic ulcer of left thigh with muscle involvement without evidence of necrosis
L97.126	Non-pressure chronic ulcer of left thigh with bone involvement without evidence of necrosis
L97.128	Non-pressure chronic ulcer of left thigh with other specified severity
L97.211	Non-pressure chronic ulcer of right calf limited to breakdown of skin

- L97.212 Non-pressure chronic ulcer of right calf with fat layer exposed
- L97.213 Non-pressure chronic ulcer of right calf with necrosis of muscle
- L97.214 Non-pressure chronic ulcer of right calf with necrosis of bone
- L97.215 Non-pressure chronic ulcer of right calf with muscle involvement without evidence of necrosis
- L97.216 Non-pressure chronic ulcer of right calf with bone involvement without evidence of necrosis
- L97.218 Non-pressure chronic ulcer of right calf with other specified severity
- L97.221 Non-pressure chronic ulcer of left calf limited to breakdown of skin
- L97.222 Non-pressure chronic ulcer of left calf with fat layer exposed
- L97.223 Non-pressure chronic ulcer of left calf with necrosis of muscle
- L97.224 Non-pressure chronic ulcer of left calf with necrosis of bone
- L97.225 Non-pressure chronic ulcer of left calf with muscle involvement without evidence of necrosis
- L97.226 Non-pressure chronic ulcer of left calf with bone involvement without evidence of necrosis
- L97.228 Non-pressure chronic ulcer of left calf with other specified severity
- L97.315 Non-pressure chronic ulcer of right ankle with muscle involvement without evidence of necrosis
- L97.316 Non-pressure chronic ulcer of right ankle with bone involvement without evidence of necrosis
- L97.318 Non-pressure chronic ulcer of right ankle with other specified severity
- L97.321 Non-pressure chronic ulcer of left ankle limited to breakdown of skin
- L97.322 Non-pressure chronic ulcer of left ankle with fat layer exposed
- L97.323 Non-pressure chronic ulcer of left ankle with necrosis of muscle
- L97.324 Non-pressure chronic ulcer of left ankle with necrosis of bone
- L97.325 Non-pressure chronic ulcer of left ankle with muscle involvement without evidence of necrosis
- L97.326 Non-pressure chronic ulcer of left ankle with bone involvement without evidence of necrosis
- L97.328 Non-pressure chronic ulcer of left ankle with other specified severity
- L97.411 Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin
- L97.412 Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed
- L97.413 Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle
- L97.414 Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone
- L97.415 Non-pressure chronic ulcer of right heel and midfoot with muscle involvement without evidence of necrosis
- L97.416 Non-pressure chronic ulcer of right heel and midfoot with bone involvement without evidence of necrosis
- L97.418 Non-pressure chronic ulcer of right heel and midfoot with other specified severity
- L97.421 Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin
- L97.422 Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed
- L97.423 Non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle
- L97.424 Non-pressure chronic ulcer of left heel and midfoot with necrosis of bone
- L97.425 Non-pressure chronic ulcer of left heel and midfoot with muscle involvement without evidence of necrosis
- L97.426 Non-pressure chronic ulcer of left heel and midfoot with bone involvement without evidence of necrosis
- L97.428 Non-pressure chronic ulcer of left heel and midfoot with other specified severity
- L98.411 Non-pressure chronic ulcer of buttock limited to breakdown of skin
- L98.412 Non-pressure chronic ulcer of buttock with fat layer exposed
- L98.413 Non-pressure chronic ulcer of buttock with necrosis of muscle
- L98.414 Non-pressure chronic ulcer of buttock with necrosis of bone
- L98.415 Non-pressure chronic ulcer of buttock with muscle involvement without evidence of necrosis
- L98.416 Non-pressure chronic ulcer of buttock with bone involvement without evidence of necrosis
- L98.418 Non-pressure chronic ulcer of buttock with other specified severity

L98.421	Non-pressure chronic ulcer of back limited to breakdown of skin
L98.422	Non-pressure chronic ulcer of back with fat layer exposed
L98.423	Non-pressure chronic ulcer of back with necrosis of muscle
L98.424	Non-pressure chronic ulcer of back with necrosis of bone
L98.425	Non-pressure chronic ulcer of back with muscle involvement without evidence of necrosis
L98.426	Non-pressure chronic ulcer of back with bone involvement without evidence of necrosis
L98.428	Non-pressure chronic ulcer of back with other specified severity
<i>L98.431</i>	<i>Non-pressure chronic ulcer of abdomen limited to breakdown of skin</i>
<i>L98.432</i>	<i>Non-pressure chronic ulcer of abdomen with fat layer exposed</i>
<i>L98.433</i>	<i>Non-pressure chronic ulcer of abdomen with necrosis of muscle</i>
<i>L98.434</i>	<i>Non-pressure chronic ulcer of abdomen with necrosis of bone</i>
<i>L98.435</i>	<i>Non-pressure chronic ulcer of abdomen with muscle involvement without evidence of necrosis</i>
<i>L98.436</i>	<i>Non-pressure chronic ulcer of abdomen with bone involvement without evidence of necrosis</i>
<i>L98.438</i>	<i>Non-pressure chronic ulcer of abdomen with other specified severity</i>
<i>L98.441</i>	<i>Non-pressure chronic ulcer of chest limited to breakdown of skin</i>
<i>L98.442</i>	<i>Non-pressure chronic ulcer of chest with fat layer exposed</i>
<i>L98.443</i>	<i>Non-pressure chronic ulcer of chest with necrosis of muscle</i>
<i>L98.444</i>	<i>Non-pressure chronic ulcer of chest with necrosis of bone</i>
<i>L98.445</i>	<i>Non-pressure chronic ulcer of chest with muscle involvement without evidence of necrosis</i>
<i>L98.446</i>	<i>Non-pressure chronic ulcer of chest with bone involvement without evidence of necrosis</i>
<i>L98.448</i>	<i>Non-pressure chronic ulcer of chest with other specified severity</i>
<i>L98.451</i>	<i>Non-pressure chronic ulcer of neck limited to breakdown of skin</i>
<i>L98.452</i>	<i>Non-pressure chronic ulcer of neck with fat layer exposed</i>
<i>L98.453</i>	<i>Non-pressure chronic ulcer of neck with necrosis of muscle</i>
<i>L98.454</i>	<i>Non-pressure chronic ulcer of neck with necrosis of bone</i>
<i>L98.455</i>	<i>Non-pressure chronic ulcer of neck with muscle involvement without evidence of necrosis</i>
<i>L98.456</i>	<i>Non-pressure chronic ulcer of neck with bone involvement without evidence of necrosis</i>
<i>L98.458</i>	<i>Non-pressure chronic ulcer of neck with other specified severity</i>
<i>L98.461</i>	<i>Non-pressure chronic ulcer of face limited to breakdown of skin</i>
<i>L98.462</i>	<i>Non-pressure chronic ulcer of face with fat layer exposed</i>
<i>L98.463</i>	<i>Non-pressure chronic ulcer of face with necrosis of muscle</i>
<i>L98.464</i>	<i>Non-pressure chronic ulcer of face with necrosis of bone</i>
<i>L98.465</i>	<i>Non-pressure chronic ulcer of face with muscle involvement without evidence of necrosis</i>
<i>L98.466</i>	<i>Non-pressure chronic ulcer of face with bone involvement without evidence of necrosis</i>
<i>L98.468</i>	<i>Non-pressure chronic ulcer of face with other specified severity</i>
<i>L98.471</i>	<i>Non-pressure chronic ulcer of groin limited to breakdown of skin</i>
<i>L98.472</i>	<i>Non-pressure chronic ulcer of groin with fat layer exposed</i>
<i>L98.473</i>	<i>Non-pressure chronic ulcer of groin with necrosis of muscle</i>
<i>L98.474</i>	<i>Non-pressure chronic ulcer of groin with necrosis of bone</i>
<i>L98.475</i>	<i>Non-pressure chronic ulcer of groin with muscle involvement without evidence of necrosis</i>
<i>L98.476</i>	<i>Non-pressure chronic ulcer of groin with bone involvement without evidence of necrosis</i>
<i>L98.478</i>	<i>Non-pressure chronic ulcer of groin with other specified severity</i>
L98.491	Non-pressure chronic ulcer of skin of other sites limited to breakdown of skin
L98.492	Non-pressure chronic ulcer of skin of other sites with fat layer exposed
L98.493	Non-pressure chronic ulcer of skin of other sites with necrosis of muscle
L98.494	Non-pressure chronic ulcer of skin of other sites with necrosis of bone
<i>L98.A111</i>	<i>Non-pressure chronic ulcer of right upper arm limited to breakdown of skin</i>
<i>L98.A112</i>	<i>Non-pressure chronic ulcer of right upper arm with fat layer exposed</i>
<i>L98.A113</i>	<i>Non-pressure chronic ulcer of right upper arm with necrosis of muscle</i>
<i>L98.A114</i>	<i>Non-pressure chronic ulcer of right upper arm with necrosis of bone</i>
<i>L98.A115</i>	<i>Non-pressure chronic ulcer of right upper arm with muscle involvement without evidence of necrosis</i>
<i>L98.A116</i>	<i>Non-pressure chronic ulcer of right upper arm with bone involvement without evidence</i>

	<i>of necrosis</i>
L98.A118	<i>Non-pressure chronic ulcer of right upper arm with other specified severity</i>
L98.A121	<i>Non-pressure chronic ulcer of left upper arm limited to breakdown of skin</i>
L98.A122	<i>Non-pressure chronic ulcer of left upper arm with fat layer exposed</i>
L98.A123	<i>Non-pressure chronic ulcer of left upper arm with necrosis of muscle</i>
L98.A124	<i>Non-pressure chronic ulcer of left upper arm with necrosis of bone</i>
L98.A125	<i>Non-pressure chronic ulcer of left upper arm with muscle involvement without evidence of necrosis</i>
L98.A126	<i>Non-pressure chronic ulcer of left upper arm with bone involvement without evidence of necrosis</i>
L98.A128	<i>Non-pressure chronic ulcer of left upper arm with other specified severity</i>
L98.A211	<i>Non-pressure chronic ulcer of right forearm limited to breakdown of skin</i>
L98.A212	<i>Non-pressure chronic ulcer of right forearm with fat layer exposed</i>
L98.A213	<i>Non-pressure chronic ulcer of right forearm with necrosis of muscle</i>
L98.A214	<i>Non-pressure chronic ulcer of right forearm with necrosis of bone</i>
L98.A215	<i>Non-pressure chronic ulcer of right forearm with muscle involvement without evidence of necrosis</i>
L98.A216	<i>Non-pressure chronic ulcer of right forearm with bone involvement without evidence of necrosis</i>
L98.A218	<i>Non-pressure chronic ulcer of right forearm with other specified severity</i>
L98.A221	<i>Non-pressure chronic ulcer of left forearm limited to breakdown of skin</i>
L98.A222	<i>Non-pressure chronic ulcer of left forearm with fat layer exposed</i>
L98.A223	<i>Non-pressure chronic ulcer of left forearm with necrosis of muscle</i>
L98.A224	<i>Non-pressure chronic ulcer of left forearm with necrosis of bone</i>
L98.A225	<i>Non-pressure chronic ulcer of left forearm with muscle involvement without evidence of necrosis</i>
L98.A226	<i>Non-pressure chronic ulcer of left forearm with bone involvement without evidence of necrosis</i>
L98.A228	<i>Non-pressure chronic ulcer of left forearm with other specified severity</i>
L98.A311	<i>Non-pressure chronic ulcer of right hand limited to breakdown of skin</i>
L98.A312	<i>Non-pressure chronic ulcer of right hand with fat layer exposed</i>
L98.A313	<i>Non-pressure chronic ulcer of right hand with necrosis of muscle</i>
L98.A314	<i>Non-pressure chronic ulcer of right hand with necrosis of bone</i>
L98.A315	<i>Non-pressure chronic ulcer of right hand with muscle involvement without evidence of necrosis</i>
L98.A316	<i>Non-pressure chronic ulcer of right hand with bone involvement without evidence of necrosis</i>
L98.A318	<i>Non-pressure chronic ulcer of right hand with other specified severity</i>
L98.A321	<i>Non-pressure chronic ulcer of left hand limited to breakdown of skin</i>
L98.A322	<i>Non-pressure chronic ulcer of left hand with fat layer exposed</i>
L98.A323	<i>Non-pressure chronic ulcer of left hand with necrosis of muscle</i>
L98.A324	<i>Non-pressure chronic ulcer of left hand with necrosis of bone</i>
L98.A325	<i>Non-pressure chronic ulcer of left hand with muscle involvement without evidence of necrosis</i>
L98.A326	<i>Non-pressure chronic ulcer of left hand with bone involvement without evidence of necrosis</i>
L98.A328	<i>Non-pressure chronic ulcer of left hand with other specified severity</i>

Effective for services on or after October 1, 2025

260.1.1– Hospital Billing Instructions

(Rev.13809, Issued:06-04-26, Effective:07-06-26, Implementation:07-06-26)

A - Hospital Outpatient Claims

For hospital outpatient claims, hospitals must bill covered dermal injections for treatment of facial LDS by having all of the required elements on the claim:

1. A line with HCPCS codes Q2026 or Q2027 with a Line Item Date of service (LIDOS) on or after March 23, 2010,

NOTE: Q2027 is replaced with Q2028 effective 1/1/14 as per the 2014 HCPCS update.

2. A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010,
3. If ICD-10-CM is applicable, ICD-10-CM diagnosis codes B20 Human Immunodeficiency Virus (HIV) disease and E88.1 Lipodystrophy, not elsewhere classified. *Effective for services on or after September 30, 2025, end date ICD-10 diagnosis code E88.1.*

Effective for services on or after October 1, 2025, add ICD-10 diagnosis code E88.14 HIV-associated lipodystrophy.