CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal: 11902	**Date: March 16, 2023**
	Change Request 13104

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 18 Sections 50.3-50.4, and Chapter 32 Sections 130.1, 170.2 for Coding Revisions to National Coverage Determinations (NCDs)--July 2023 Change Request (CR) 13070

I. SUMMARY OF CHANGES: The purpose of this CR is to make updates to chapters 18 and 32 of the Medicare Claims Processing Manual Pub. 100-04 to coincide with the NCD updates in CR13070.

EFFECTIVE DATE: April 17, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 17, 2023

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	18/50/50.3/Payment Method - A/B MACs (A) and (B)
R	18/50/50.4/HCPCS, Revenue, and Type of Service Codes
R	32/130/130.1/Billing and Payment Requirements
R	32/170/170.2/Carrier Billing Requirements

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: 11902	Date: March 16, 2023	Change Request: 13104

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I. GENERAL INFORMATION

A. Background: This CR constitutes updates to Pub. 100-04, Chapter 18, Sections 50.3, 50.4; Chapter 32, Sections 130.1, and 170.2 for the Billing Requirements of the Medicare Claims Processing manual due to NCDs 20.20, 150.10 and 210.1 in CR 13070, International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--July 2023 Update.

In CR 13070, the Medicare contractors were advised to end date Current Procedural Terminology (CPT) codes 99217, 99218, 99219, 99220, and 99241 effective December 31, 2022 in reference to the External Counterpulsation Therapy NCD 20.20. In addition, effective January 1, 2023, the Medicare contractors were advised to add the following CPT/ Healthcare Common Procedure Coding System (HCPCS): CPT 0359U for Prostate Cancer Screening NCD 210.1 and CPT 22860 - Lumbar Artificial Disc Replacement NCD 150.10.

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

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13104.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 18, Sections 50.3 and 50.4.	X	X							
13104.2	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 32, Sections 130.1 and 170.2.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cindy Pitts, Cindy.Pitts@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

50.3 - Payment Method - A/B MACs (A) and (B)

(Rev.11902; Issued:03-16-23; Effective: 04-17-23; Implementation: 04-17-23)

Screening PSA tests (G0103) are paid under the clinical diagnostic lab fee schedule.

Screening PSA tests (Effective 01/01/23 (0359U)) new codes are contractor-priced (where applicable) until they are nationally priced and undergo the CLFS annual payment determination process.

Screening rectal examinations (G0102) are paid under the MPFS except for the following bill types identified (A/B MAC (A) only). Bill types not identified are paid under the MPFS.

12X = Outpatient Prospective Payment System
13X = Outpatient Prospective Payment System
14X-=Outpatient Prospective Payment System
71X = Included in All Inclusive Rate
73X = Included in All Inclusive Rate
85X = Cost (Payment should be consistent with amounts paid for code 84153 or code 86316.)

Effective 4/1/06 the type of bill 14X is for non-patient laboratory specimens.

The RHCs and FQHCs should include the charges on the claims for future inclusion in encounter rate calculations.

50.4 - HCPCS, Revenue, and Type of Service Codes

(Rev.11902; Issued:03-16-23; Effective: 04-17-23; Implementation: 04-17-23)

The appropriate bill types for billing the A/B MAC (A) on Form CMS-1450 or its electronic equivalent are 12X, 13X, 14X, 22X, 23X, 71X, 73X, 75X, and 85X. Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.

The HCPCS code G0102 - for prostate cancer screening digital rectal examination.

- A/B MAC (B) TOS is 1
- A/B MAC (A) revenue code is 0770

The HCPCS code G0103 - for prostate cancer screening PSA tests

- A/B MAC (B) TOS is 5
- A/B MAC (A) revenue code is 030X

The HCPCS code 0359U – (PROSTATE CANCER), ANALYSIS OF ALL PROSTATE-SPECIFIC ANTIGEN (PSA) STRUCTURAL ISOFORMS BY PHASE SEPARATION AND IMMUNOASSAY, PLASMA, ALGORITHM REPORTS RISK OF CANCER. Effective 01/01/23.

- *A/B MAC (B) TOS is 5*
- *A/B MAC (A) revenue code is 030X*

130.1 - Billing and Payment Requirements
(Rev.11902; Issued:03-16-23; Effective: 04-17-23; Implementation: 04-17-23)

Effective for dates of service on or after January 1, 2000, use HCPCS code G0166 (External counterpulsation, per session) to report ECP services. The codes for external cardiac assist (92971), ECG rhythm strip and report (93040 or 93041), pulse oximetry (94760 or 94761) and plethysmography (93922 or 93923) or other monitoring tests for examining the effects of this treatment are not clinically necessary with this service and should not be paid on the same day, unless they occur in a clinical setting not connected with thedelivery of the ECP. Daily evaluation and management service, e.g., 99201- 99205, 99211-99215, 99217-99220, 99241-99245, cannot be billed with the ECP treatments. Any evaluation and management service must be justified with adequate documentation of the medical necessity of the visit. Deductibleand coinsurance apply.

Note: Please note that effective December 31, 2020 evaluation and management service code 99201 is end-dated. *Effective December 31, 2022 codes 99217,99218,99219,99220 and 99241 are end dated.*

170.2 - Carrier Billing Requirements
(Rev.11902; Issued:03-16-23; Effective: 04-17-23; Implementation: 04-17-23)

Effective for services performed on or after May 16, 2006 through December 31, 2006, carriers shall deny claims, for Medicare beneficiaries over 60 years of age, submitted with the following Category III Codes:

- 0091T Single interspace, lumbar; and
- 0092T Each additional interspace (List separately in addition to code for primary procedure.)

Effective for services performed on or after January 1, 2007 through August 13, 2007, for Medicare beneficiaries over 60 years of age, LADR with the Charite™ lumbar artificial disc, carriers shall deny claims submitted with the following codes:

- 22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace
- 0163T Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, each additional interspace. *NOTE: Effective December 31, 2022, code 0163T is end dated.*

Carriers shall continue to follow their normal claims processing criteria for IDEs for LADR performed with an implant eligible under the IDE criteria.

For dates of service May 16, 2006 through August 13, 2007, Medicare coverage under the investigational device exemption (IDE) for LADR with a disc other than the Charite™ lumbar disc in eligible clinical trials is not impacted.

Effective for services performed on or after August 14, 2007, carriers shall deny claims for LADR surgery, for Medicare beneficiaries over 60 years of age, (i.e., on or after a beneficiary's 61st birthday) submitted with the following codes:

- 22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace
- 0163T Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, each additional interspace *NOTE: Effective December 31, 2022, code 0163T is end dated.*
- *22860 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar. Effective 01/01/23*