CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal: 12185	**Date: August 3, 2023**
	Change Request 13288

SUBJECT: National Coverage Determination (NCD) 30.3.3 Acupuncture for Chronic Low Back Pain Revised Frequency Edits

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise the editing around frequency for NCD 30.3.3, Acupuncture for Chronic Low Back Pain, so that it aligns with the intention of the NCD policy.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

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
N	32/410/410.1.1/TOC/Acupuncture for Chronic Low Back Pain (cLBP)
R	32/410/410.1/Coverage Requirements
N	32/410/410.1.1/HCPCS Coding Associated with Acupuncture and Dry Needling Services
R	32/410/410.4/Messaging
R	32/410/410.5/Common Working File (CWF), FISS, and Multi-Carrier System (MCS) Editing

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: 12185	Date: August 3, 2023	Change Request: 13288

SUBJECT: National Coverage Determination (NCD) 30.3.3 Acupuncture for Chronic Low Back Pain Revised Frequency Edits

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to revise the manner in which the Common Working File (CWF) is editing for frequency for National Coverage Determination (NCD) 30.3.3, Acupuncture for Chronic Low Back Pain (cLBP). NCD 30.3.3 was effective for claims with dates of service on and after January 21, 2020. An implementing Change Request (CR) 11755, Transmittal 10337, was issued on August 27, 2020, with an implementation date of October 5, 2020. NCD 30.3.3 covers up to 12 visits in 90 days for cLBP defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and, • not associated with pregnancy. An additional 8 sessions are covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.

The associated HCPCS codes are:

97810 Acupuncture, 1 or more needles, without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

97811 Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure.)

97813 Acupuncture, 1 or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

97814 Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure.)

20560 Needle insertion(s) without injection(s); 1 or 2 muscle(s)

20561 Needle insertion(s) without injection(s); 3 or more muscle(s)

B. Policy: Effective for claims with dates of service on and after January 1, 2024:

One initial acupuncture HCPCS (97810 OR 97813) shall be allowed to be reported with or without HCPCS add-on code(s) (97811 AND/OR 97814) on the same date of service (DOS) and this equals one session. It doesn't matter which initial code with which subsequent codes are reported but only one initial code HCPCS 97810 OR 97813 can be reported per DOS.

Dry needling HCPCS 20560 OR 20561 shall be allowed to be reported and this equals one session. Dry needling and acupuncture are disallowed on the same DOS. HCPCS 20560 & 20561 are disallowed on the

same DOS as HCPCS 97810, 97811, 97813, or 97814).

All other existing editing other than the frequency described above that is contained in CRs 11755, 12480, and 12822, remain in effect.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13288.1	Effective for claims with dates of service on and after January 1, 2024, CWF shall count as one session (toward a total of 20 sessions, see initial implementing CR 11755) as follows: -Initial acupuncture HCPCS 97810 OR 97813, with or without acupuncture HCPCS add-on codes 97811 AND/OR 97814 on the same date of service (DOS). It doesn't matter which initial code is reported with which add-on code but only one initial HCPCS 97810 or 97813 are allowed per DOS. -Dry needling HCPCS 20560 OR 20561. HCPCS 20560 and 20561 are not allowed on the same DOS. Dry needling and acupuncture are not allowed on the same DOS. CPT codes 97810, 97811, 97813, or 97814 are disallowed on the same DOS as CPT codes 20560 and 20561.								X	
13288.2	Effective January 1, 2024, contractors shall not search claims but shall adjust claims that are brought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13288.3	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.					

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

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

Table of Contents

(Rev.12185; Issued:08-03- 23)

Transmittals for Chapter 32

410.1 - Coverage Requirements

(Rev. 12185; Issued:08-03- 23, Effective:01-01-24; Implementation:01-02-24)

Effective for services on or after January 21, 2020, the Centers for Medicare & Medicaid Services (CMS) will cover acupuncture for chronic low back pain (cLBP) under section 1862(a)(1)(A) of the Social Security Act. Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:

- For the purpose of this decision, cLBP is defined as:
    - Lasting 12 weeks or longer;
    - nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);
    - not associated with surgery; and
    - not associated with pregnancy.
- An additional 8 sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Example: If the 1st service is performed on March 21, 2020, the next service beginning a new year cannot be performed until March 1, 2021. This means 11 full months must pass from the date of the 1st service before eligibility begins again.

Effective for claims received on and after January 1, 2024:

One initial acupuncture Healthcare Common Procedure Coding System (HCPCS) (97810 OR 97813) shall be allowed to be reported with or without acupuncture HCPCS add-on code(s) (97811 AND/OR 97814) on the same date of service (DOS) and this equals one session. It doesn't matter which initial code is reported with which add-on code but only one initial HCPCS 97810 OR 97813 is allowed per DOS.

Dry needling HCPCS 20560 OR 20561 shall be allowed to be reported and this equals one session. Dry needling HCPCS 20560 and 20561 are disallowed on the same DOS.

Acupuncture HCPCS 97810, 97811, 97813, and 97814 are disallowed on the same DOS as HCPCS dry needling 20560 and 20561.

410.1.1 HCPCS Coding Associated with Acupuncture and Dry Needling Services

(Rev. 12185; Issued:08-03- 23, Effective:01-01-24; Implementation:01-02-24)

97810 Acupuncture, 1 or more needles, without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

97811 Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure.)

97813 Acupuncture, 1 or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

97814 Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure.)

20560 Needle insertion(s) without injection(s); 1 or 2 muscle(s)

20561 Needle insertion(s) without injection(s); 3 or more muscle(s)

410.4 – Messaging

(Rev. 12185; Issued:08-03- 23, Effective:01-01-24; Implementation:01-02-24)

Effective for claims with DOS on or after January 21, 2020, contractors shall reject/deny claims that do not contain the appropriate diagnosis/procedure coding noted in section 410.2 and use these messages:

Claim Adjustment Reason Code (CARC) 50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Remittance Advice Remark Code (RARC) M64 – Missing/incomplete/invalid other diagnosis.

Group Code CO (Contractual Obligations) or PR (Patient Responsibility) dependent on liability.

MSN 15.20 - “The following polices were used when we made this decision: NCD 30.3.3.”

Spanish Version – “Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 30.3.3.”

NOTE: Due to system requirement, the Fiscal Intermediary Shared System (FISS) has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

In addition to the codes noted in section 410.2, contractors shall afford appeal rights to all denied parties.

Contractors shall return to provider/return as unprocessable claims for acupuncture for cLBP for services 13 through 20 per annum without the -KX modifier and use these messages:

CARC 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N657 - This should be billed with the appropriate code for these services.

Group Code CO

Contractors shall reject/deny more than 20 claims per annum for acupuncture for cLBP and use the following messages:

CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N640 - Exceeds number/frequency approved/allowed within time period.

Group Code - CO (Contractual Obligation)

MSN 15.20 - “The following polices were used when we made this decision: NCD 30.3.3.”

Spanish Version – “Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 30.3.3.”

MSN 15.19: “We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.

NOTE: Due to system requirements, the Fiscal Intermediary Shared System *(FISS)* has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

In addition to the codes listed above, contractors shall afford appeal rights to all denied parties.

410.5 – Common Working File (CWF), FISS, and Multi-Carrier System (MCS) Editing

(Rev. 12185; Issued:08-03- 23, Effective:01-01-24; Implementation:01-02-24)

The Common Working File (CWF) shall create a new reject for claims with DOS on and after January 21, 2020, for claims received on or after October 5, 2020, to not allow payment for more than 20 acupuncture for cLBP claims per annum.

For acupuncture for cLBP claims CWF, FISS and the Multi-Carrier System (MCS) shall apply appropriate updates to the Next Eligibility Date file for DOS on or after January 21, 2020.

NOTE: Appropriate updates include modifications to HUQA, and Extract Records on the Next Generation Desktop (NGD) and the Medicare Beneficiary Database (MBD) for next eligible date and services remaining.

CWF shall count 11 full months starting with the month of a beneficiary's 1st acupuncture for cLBP service. EX: If 1st date of service is October 15, 2020, the next eligible date beginning a new year would be October 1, 2021.

NOTE: A new cLBP auxiliary (AUX) file will be created and HIMR will be updated to post the previous acupuncture for cLBP HCPCS 97810, 97811, 97813, 97814, 20560, or 20561.

For acupuncture for cLPB claims with DOS on and after January 21, 2020, the Multi-Carrier System Desktop Tool shall display the acupuncture for cLBP visits in a format equivalent to the CWF HIMR screen.

Effective for claims with DOS on and after January 21, 2020, received on and after October 5, 2020, CWF shall post acupuncture for cLBP HCPCS codes 97810, 97811, 97813, 97814, 20560, and 20561, reported on institutional claims, TOBs 12X, 13X, 71X, 77X, and 85X (and revenue code not equal to 096X, 097X, 098X), as the technical component on the new cLBP AUX file.

NOTE: 1 TECH and 1 PROF on same DOS represents 1 service.

NOTE: CWF shall post the Part B Professional claim line as TECH/PROF for the HCPCS if the modifier is blank.

Effective for claims received on or after January 1, 2024, CWF shall allow one initial acupuncture HCPCS (97810 OR 97813) to be reported with or without add-on HCPCS (97811 AND/OR 97814) on the same date of service (DOS) and this equals one session. It doesn't matter which initial code is reported with which add-on code but only one initial HCPCS 97810 or 97813 per DOS is allowed.

CWF shall allow dry needling HCPCS 20560 OR 20561 to be reported and this equals one session. CWF shall disallow dry needling 20560 and 20561 on the same DOS.

CWF shall disallow acupuncture HCPCS 97810, 97811, 97813, and 97814 on the same DOS as HCPCS dry needling 20560 and 20561.

CWF shall create a new reject for HCPCS 97810, 97811, 97813, 97814, 20560, and 20561 when a beneficiary has reached 20 acupuncture for cLBP sessions and the -KX modifier is not included on the claim line for sessions 13 through 20 (the reject will apply for both PROF and TECH sessions).

CWF shall update the determination when any changes occur to the beneficiary master data or claims data that would result in a change to the calculation.

CWF shall create a new HICR function for the new cLBP AUX file.