CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11161	**Date: December 14, 2021**
	Change Request 12376

Transmittal 11021, dated October 1, 2021, is being rescinded and replaced by Transmittal 11161, dated, December 14, 2021 to update Chapter 18 section 150.3 to ensure the CPM aligns with the NCD quarterly coding CRs. All other information remains the same.

SUBJECT: REVISIONS TO CHAPTERS 13,18 AND 32 TO UPDATE CODING

I. SUMMARY OF CHANGES: This Change Request (CR) makes updates to chapters 13,18 and 32 of the Medicare Claims Processing Manual Pub. 100-04.

EFFECTIVE DATE: October 29, 2021 - Unless otherwise specified, the effective date is the date of service
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 29, 2021 - Unless otherwise specified, the effective date is the date of service

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	32/Table of Contents
R	13/ 60.12/Coverage for PET Scans for Dementia and Neurodegenerative Diseases
R	18/ 30.6/Screening Pap Smears: Diagnoses Codes
R	18/30.8/ MSN Messages
R	18/30.9/ Remittance Advice Codes
R	18/40.1/ Screening Pelvic Examinations From January 1, 1998, Through June 30 2001
R	18/40.4/ Diagnoses Codes
R	18/40.7/ MSN Messages
R	18/50.5/ Diagnosis Coding
R	18/50.8/ Remittance Advice Notices
R	18/150/ Counseling to Prevent Tobacco Use
R	18/150.1/ Healthcare Common Procedure Coding System [HCPCS] and Diagnosis Coding
R	18/150.2/A/B MACs [B] Billing Requirements
R	18/150.2.1/ A/B MAC [A] and [HHH] Billing Requirements
R	18/150.3/ Claims Adjustment Reason Codes [CARCs], Remittance Advice Remark Codes [RARCs], Group Codes, and Medicare Summary Notices [MSNs]
R	18/150.4/ Common Working File [CWF]
R	18/170.2/ Diagnosis Code Reporting
R	18/170.3/ Billing Requirements
R	18/210.3/ Claim Adjustment Reason Codes [CARCs], Remittance Advice Remark Codes [RARCs], Group Codes, and Medicare Summary Notice [MSN] Messages
R	18/210.4/ Common Working File [CWF] Edits
R	32/10.1/ Ambulatory Blood Pressure Monitoring [ABPM] Billing Requirements
R	32/30.1/ Billing Requirements for HBO Therapy for the Treatment of Diabetic Wounds of the Lower Extremities
R	32/50.3.2/ Bill Types
R	32/50.4.1/ Allowable Covered Diagnosis Codes
R	32/50.4.2/ Allowable Covered Procedure Codes
R	32/50.4.3/ Healthcare Common Procedure Coding System [HCPCS]
R	32/60.12/ Coverage for PET Scans for Dementia and Neurodegenerative Diseases
R	32/70.4/ Special Billing and Payment Requirements for A/B MACs [A]

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/80.3/ Diagnosis Codes
R	32/80.6/ Editing Instructions for A/B MACs [A]
R	32/140.4.2.1/ Correct Place of Service [POS] Code for PR Services on Professional Claims
R	32/140.4.2.2/ Requirements for PR Services on Institutional Claims
R	32/140.4.2.5/ Edits for PR Services Exceeding 72 Sessions
R	32/150.3/ ICD Procedure Codes for Bariatric Surgery for Treatment of Co- Morbid Conditions Related to Morbid Obesity [A/MACs only]
R	32/150.4/ ICD Diagnosis Codes for Bariatric Surgery
R	32/150.5/ ICD Diagnosis Codes for BMI □35
R	32/150.5.1/ ICD Codes for Type II Diabetes Mellitus Complication
R	32/150.6/ Claims Guidance for Payment
R	32/150.7/ Medicare Summary Notices [MSNs] and Claim Adjustment Reason Codes
R	32/160.2.1/ Carotid Artery Stenting [CAS] for Post-Approval Studies
R	32/160.4/ 510k Post-Approval Extension Studies using 510k-Cleared Embolic Protection Devices during Carotid Artery Stenting [CAS] Procedures
R	32/161/ Intracranial Percutaneous Transluminal Angioplasty [PTA] With Stenting
R	32/250.2/ Billing Requirements
R	32/250.3/ Payment Requirements
R	32/260.1.1/ Hospital Billing Instructions
R	32/260.2.2/ Practitioner Billing Instructions
R	32/260.3/ Claims Processing System Editing
R	32/300.2/ Claims Processing Requirements for OPT with Verteporfin Services on Professional Claims and Outpatient Facility Claims
R	32/300.3/ Claims Processing Requirements for OPT with Verteporfin Services on Inpatient Facility Claims
R	32/370.1/ Coding and Claims Processing for MTWA

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: 11161	Date: December 14, 2021	Change Request: 12376

Transmittal 11021, dated October 1, 2021, is being rescinded and replaced by Transmittal 11161, dated, December 14, 2021 to update Chapter 18 section 150.3 to ensure the CPM aligns with the NCD quarterly coding CRs. All other information remains the same.

SUBJECT: REVISIONS TO CHAPTERS 13,18 AND 32 TO UPDATE CODING

EFFECTIVE DATE: October 29, 2021 - Unless otherwise specified, the effective date is the date of service
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IMPLEMENTATION DATE: October 29, 2021 - Unless otherwise specified, the effective date is the date of service

I. GENERAL INFORMATION

A. Background: This Change Request (CR) constitutes an update to Pub. 100-04, Chapter 13, Section 60.12; Chapter 18, Sections 30.6, 30.8, 30.9,40.1,40.4, 40.7, 50.5, 50.8, 150, 150.1, 150.2, 150.2.1, 150.3, 150.4, 170.2, 170.3, 210.3, 210.4; Chapter 32, Sections 10.1, 30.1, 50.3.2, 50.4.1, 50.4.2, 50.4.3, 60.12, 70.4, 80.3, 80.6, 140.4.2.1, 140.4.2.2 , 140.4.2.5, 150.3, 150.4, 150.5, 150.5.1, 150.6, 150.7, 160.2.1, 160.4, 161, 250.2, 250.3, 260.1.1, 260.2.2, 260.3. 300.2, 300.3, 370.1 for the Billing Requirements of the Medicare Claims Processing manual due to NCDs 20.7, 20.19, 20.29, 30.30, 70.2.1, 80.2 80.2.1 80.3 80.3.1, 90.1, 100.1, 160.24, 210.1, 210.2, 210.4.1, 210.10, 210.13, 220.6.20, 250.5, and 260.3.1 in CRs 8691, 9087, 9252, 9540, 9631, 9751, 9861, 9982, 10086, 10184, 10318, 10473, 11005 and 11134 for May 2014 - July-2019 update in International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs).

B. Policy: There are no regulatory, legislative or statutory requirements related to this CR.

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	
12376.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04 Chapter 13, Section 60.12 Chapter 18, Sections 30.6, 30.8, 30.9, 40.1, 40.4, 40.7, 50.5, 50.8, 150, 150.1, 150.2, 150.2.1, 150.3, 150.4, 170.2, 170.3, 210.3, and 210.4	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Chapter 32, Sections 10.1, 30.1, 50.3.2, 50.4.1, 50.4.2, 50.4.3, 60.12, 70.4, 80.3, 80.6, 140.4.2.1, 140.4.2.2 , 140.4.2.5, 150.3, 150.4, 150.5, 150.5.1, 150.6, 150.7, 160.2.1, 160.4, 161, 250.2, 250.3, 260.1.1, 260.2.2, 260.3. 300.2, 300.3, and 370.1									

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): Kajol Balani, Kajol.Balani@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

Medicare Claims Processing Manual
Chapter 13 - Radiology Services and Other Diagnostic Procedures

Table of Contents
(Rev.11161, Issued: 12-14-21)

60.12 - Coverage for PET Scans for Dementia and Neurodegenerative Diseases
(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Effective for dates of service on or after September 15, 2004, Medicare will cover FDG PET scans for a differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease OR; its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases. Refer to Pub. 100-03, NCD Manual, section 220.6.13, for complete coverage conditions and clinical trial requirements and section 60.15 of this manual for claims processing information.

A. A/B MAC (A and B) Billing Requirements for PET Scan Claims for FDG-PET for the Differential Diagnosis of Fronto-temporal Dementia and Alzheimer's Disease:

CPT Code for PET Scans for Dementia and Neurodegenerative Diseases

Contractors shall advise providers to use the appropriate CPT code from section 60.3.1 for dementia and neurodegenerative diseases for services performed on or after January 28, 2005.

Diagnosis Codes for PET Scans for Dementia and Neurodegenerative Diseases

The contractor shall ensure one of the following appropriate diagnosis codes is present on claims for PET Scans for AD:

- *ICD-10-CM is applicable, ICD-10 codes are: F03.90, F03.90 plus F05, G30.9, G31.01, G31.9, R41.2 or R41.3*

Medicare contractors shall deny claims when submitted with an appropriate CPT code from section 60.3.1 and with a diagnosis code other than the range of codes listed above.

Medicare contractors shall instruct providers to issue an Advanced Beneficiary Notice to beneficiaries advising them of potential financial liability prior to delivering the service if one of the appropriate diagnosis codes will not be present on the claim.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR (if claim is received with a GA modifier) otherwise CO
CARC: 11
RARC: N/A
MSN: 16.48

Provider Documentation Required with the PET Scan Claim

Medicare contractors shall inform providers to ensure the conditions mentioned in the NCD Manual, section 220.6.13, have been met. The information must also be maintained in the beneficiary's medical record:

- Date of onset of symptoms;
- Diagnosis of clinical syndrome (normal aging, mild cognitive impairment or MCI: mild, moderate, or severe dementia);
- Mini mental status exam (MMSE) or similar test score;
- Presumptive cause (possible, probably, uncertain AD);
- Any neuropsychological testing performed;
- Results of any structural imaging (MRI, CT) performed;
- Relevant laboratory tests (B12, thyroid hormone); and,
- Number and name of prescribed medications.

B. Billing Requirements for Beta Amyloid Positron Emission Tomography (PET) in Dementia and Neurodegenerative Disease:

Effective for claims with dates of service on and after September 27, 2013, Medicare will only allow coverage with evidence development (CED) for Positron Emission Tomography (PET) beta amyloid (also referred to as amyloid-beta (Aβ)) imaging (HCPCS A9586)or *(HCPCS Q9982) or (HCPCS Q9983)* (one PET Aβ scan per patient).

NOTE: Please note that effective January 1, 2014 the following code A9599 will be updated in the IOCE and HCPCS update. This code will be contractor priced.

Note: Please note that effective January 1, 2018 the following code A9599 is end-dated.

Medicare Summary Notices, Remittance Advice Remark Codes, and Claim Adjustment Reason Codes

Effective for dates of service on or after September 27, 2013, contractors shall **return as unprocessable/return to provider** claims for PET Aβ imaging, through CED during a clinical trial, not containing the following:

- *Condition code 30, and value code D4 (A/B MAC (A) only)*
- *Modifier Q0 as appropriate*
- ICD-*10* dx code Z00.6 *(in either the primary/secondary position)*
- A PET HCPCS code (78811 or 78814)
- At least, one Dx code from the table below,

And one of these additional ICD-10 diagnoses is required in addition to Z00.6

F03.90	*Unspecified dementia without behavioral disturbance*
F03.91	*Unspecified dementia with behavioral disturbance*
F01.50	*Vascular dementia without behavioral disturbance*
F01.51	*Vascular dementia with behavioral disturbance*
F02.80	*Dementia in other diseases classified elsewhere without behavioral disturbance*
F02.81	*Dementia in other diseases classified elsewhere with behavioral disturbance*
G31.01	*Pick's disease*
G31.09	*Other frontotemporal dementia*
G31.85	*Corticobasal degeneration*
G31.83	*Dementia with Lewy bodies*
G31.84	*Mild cognitive impairment, so stated*

R41.1	*Anterograde amnesia*
R41.2	*Retrograde amnesia*
R41.3	*Other amnesia (amnesia NOS, memory loss NOS)*

and

- Aβ HCPCS code A9586 or *Q9982 or Q9983*

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 4
RARC: N519
MSN: N/A

Contractors shall line-item **deny** claims for PET Aβ, HCPCS code A9586 or *Q9982 or Q9983*, where a previous PET Aβ, HCPCS code A9586 or *Q9982 or Q9983* is paid in history.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR (if claim is received with a GA modifier) otherwise CO
CARC: 149
RARC: N587
MSN: 20.12

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev.11161; Issued: 12-14-21)

30.6 - Screening Pap Smears: Diagnoses Codes
(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

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
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
Z91.89	Other specified personal risk factors, not elsewhere classified
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, Z77.29, Z72.51, Z72.52, Z72.53, Z77.9, Z91.89, and Z92.89. (Effective Oct 1, 2015)* One of the above diagnoses must be listed in item 21of 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.**

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

Providers report one of the following diagnosis codes in Form CMS-1450 or the electronic equivalent (**NOTE:** Information regarding the form locator numbers that correspond to the diagnosis codes and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.):

Low-risk ICD-10-diagnosis codes *for every 2 years:*

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*

High-risk ICD-10 diagnosis *codes for every year:*

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*
Z91.89	*Other specified personal risk factors, not elsewhere classified*
Z92.89	*Personal history of other medical treatment*

Periodically provider education should be done on diagnosis coding of Pap smear claims.

C. HPV Screening: Applicable Diagnoses for Billing A/B MAC (A/B)

Effective for claims with dates of service on or after July 9, 2015, providers shall report the following diagnosis codes when submitting claims for HCPCS G0476 - Cervical cancer screening, all-inclusive HPV co-test with cytology (Pap smear) to detect HPV DNA or RNA sequences:

ICD-10: Z11.51, encounter for screening for HPV, and Z01.411, encounter for gynecological exam (general)(routine) with abnormal findings, OR, Z01.419, encounter for gynecological exam (general)(routine) without abnormal findings.

30.8 - MSN Messages

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

If there are no high risk factors, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed use MSN 18.17:

> Medicare pays for a screening Pap smear and/or screening pelvic examination only once every (2, 3) years unless high risk factors are present.

HPV Screening: Effective for claims with dates of service on and after July 9, 2015:

A. If denying line-items on claims containing HCPCS G0476, HPV screening, when reported more than once in a 5-year period [at least 4 years and 11 full months (59 months total) must elapse from the date of the last screening], use the following messages:

(Part A Only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD 210.2.1 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD 210.2.1 fueron utilizadas cuando se tomó esta decisión."

B. If denying line-items on claims containing HCPCS G0476, HPV screening, when the beneficiary is not between the ages of 30-65, use the following messages:

(Part A Only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD 210.2.1 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD 210.2.1 fueron utilizadas cuando se tomó esta decisión."

C. If denying line-items on claims containing HCPCS G0476, HPV screening, when the claim does not contain the appropriate ICD-10 diagnosis codes listed below:

ICD-10: Z11.51 and Z01.411 or, Z01.419

Use the following messages:

(Part A Only)MSN 15.19: “Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD”.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: “The following policies NCD 210.2.1 were used when we made this decision.”

Spanish Version – “Las siguientes políticas NCD 210.2.1 fueron utilizadas cuando se tomó esta decisión.”

30.9 - Remittance Advice Codes

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Pap Smear Screening: If high risk factors are not present, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, use existing ANSI X12N 835:

- Claim adjustment reason code 119 - “Benefit maximum for this time period has been reached” at the line level, and

- Remark code M83 - “Service is not covered unless the patient is classified as at high risk” at the line item level.

HPV Screening: Effective for claims with dates of service on and after July 9, 2015:

A. If denying line-items on claims containing HCPCS G0476, HPV screening, when reported more than once in a 5-year period [at least 4 years and 11 months (59 months total) must elapse from the date of the last screening], use the following messages:

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

RARC N386: “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

B. If denying line-items on claims containing HCPCS G0476, HPV screening, when the beneficiary is not between the ages of 30-65, use the following messages:

CARC 6: “The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

RARC N129: “Not eligible due to the patient’s age.”

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

C. If denying line items on claims containing HCPCS G0476, HPV screening, when the claim does not contain the appropriate ICD-10 diagnosis codes listed below:

ICD-10: Z11.51 and Z01.411, or, Z01.419

Use the following messages:

CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

Group Code CO assigning financial liability to the provider

40.1 - Screening Pelvic Examinations From January 1, 1998, Through June 30 2001

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

B3-4603.2.A, B3-4603.5, A3-3628.1.B.1, R1888.A.3 Dated 6-3-2003

The following requirements must be met.

The exam must be performed by a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act), or by a certified nurse midwife (as defined in §1861(gg) of the Act), or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in §1861(aa) of the Act) who is authorized under State law to perform the examination. This examination does not have to be ordered by a physician or other authorized practitioner.

Payment may be made: Once every three years on an asymptomatic woman only if the individual has not had a screening pelvic examination paid for by Medicare during the preceding 35 months following the month in which the last Medicare-covered screening pelvic examination was performed. *Providers use ICD-10-CM codes for the low risk factors*. Exceptions are as follows:

- Payment may be made for a screening pelvic examination performed more frequently than once every 35 months if the test is performed by a physician or other practitioner and there is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical cancer, or vaginal cancer. *Providers use ICD-10-CM codes for the high risk factors for cervical and vaginal cancer are:*

  Cervical Cancer High Risk Factors

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of a sexually transmitted disease (including HIV infection)
- Fewer than three negative or any Pap smears within the previous seven years

Vaginal Cancer High Risk Factors

- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

ICD-10-CM code Z92.89, Personal history of other medical treatment is used to indicate that one or more of these factors is present; or

- Payment may also be made for a screening pelvic examination performed more frequently than once every 36 months if the examination is performed by a physician or other practitioner, for a woman of childbearing age, who has had such an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding three years. The term "women of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings. Payment is not made for a screening pelvic examination for women at high risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after the month that the last screening pelvic examination covered by Medicare was performed.

- For claims with dates of service on or after July 1, 2001, if the beneficiary does not qualify for an annual screening pelvic exam as noted above, pay for the screening pelvic exam only after at least 23 months have passed following the month during which the beneficiary received her last covered screening pelvic exam. All other coverage and payment requirements remain the same.

Calculating the Frequency Limitations

To determine the screening periods, start counts beginning with the month after the month in which a previous test/procedure was performed.

Frequency Limitation Example

A beneficiary identified as being at high risk for developing cervical cancer received a pelvic exam in January 2002. Start counts beginning with February 2002. The beneficiary is eligible to receive another screening exam, if high risk, in January 2003 (the month after 11 full months have passed).

40.4 - Diagnoses Codes

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Below are the current diagnoses that should be used when billing for screening pelvic examination services. *Effective Oct 1, 2015* the following chart lists for the *ICD-10-CM* codes that CWF must recognize for low risk or high-*risk patients for screening pelvic examination services.*

Low Risk Diagnosis Codes

ICD-*10*-CM codes	Description
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*

High Risk Diagnosis Codes

ICD-*10*-CM codes	Description
Z77.9	*Other contact with and (suspected) exposures hazardous to health*
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*
Z91.89	*Other specified personal risk factors, not elsewhere classified*
Z92.89	*Personal history of other medical treatment*

A. Applicable Diagnoses for Billing an A/B MAC (B)

For professional claims, providers report diagnosis codes according to the instructions in the ASC X12 837 professional claim technical report 3 for electronic claims and chapter 26 of this manual for paper claims. Part of this reporting includes pointing (relating) the claimed service to a diagnosis code on the claim.

There are a number of appropriate diagnosis codes that can be used in billing for screening pelvic examinations that the provider can list on the claim to give a true picture of the patient's condition. In addition, one of the diagnoses listed in either the high risk or low risk tables above (§40.4) must be on the claim to indicate either low risk or high risk depending on the patient's condition, and the screening pelvic examination service must point to this diagnosis code. Providers must make sure that, for screening pelvic exams for a high risk beneficiary, a high risk diagnosis code appears on the claim and that the screening pelvic examination service points to this diagnosis code. If pelvic examination claims do not point to one of

these specific diagnoses, the claim will reject in the CWF. If these pointers are not present on claims submitted to A/B MACs (B), CWF will reject the record.

Periodically, A/B MACs (B) should do provider education on diagnosis coding of screening pelvic examination claims.

B. Applicable Diagnoses for Billing an A/B MAC (A)

For institutional claims, providers report diagnosis codes according to the instructions in the ASC X12 837 institutional claim technical report 3 for electronic claims and chapter 25 of this manual for paper claims. (Chapter 25 also contains additional general billing information for institutional claims.)

Appropriate diagnoses are shown above in this section for low risk and high risk beneficiaries.

Periodically provider education should be done on diagnosis coding of screening pelvic exam claims.

40.7 - MSN Messages

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

If there are no high risk factors, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, A/B MACs (A) and (B) use MSN *18.17*:

- Medicare pays for a screening Pap smear and/or screening pelvic examination only once every (2, 3) years unless high risk factors are present.

50.5- Diagnosis Coding

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Prostate cancer screening digital rectal examinations and screening Prostate Specific Antigen (PSA) blood tests must be billed using either screening code if ICD-10-CM is applicable, diagnosis code Z12.5 (Encounter for screening for malignant neoplasm of prostate).

50.8 - Remittance Advice Notices

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

If the claim for a screening prostate antigen test or screening digital rectal examination is being denied because the patient is less than 50 years of age, use the ASC X12 835 with

- Claim adjustment reason code; 6 “the procedure/revenue code is inconsistent with the patient’s age,” at the line level; and

- *Remark code* M*82 “*Service not covered *when patient is under age 50.”*

If the claim for a screening prostate specific antigen test or screening digital rectal examination is being denied because the time period between the test/procedure has not passed, A/B MACs (A) and (B) use ASC X12 835 claim adjustment reason code 119, “Benefit maximum for this time period has been reached” at the line level.

If the claim for a screening prostate antigen test or screening digital rectal examination is being denied due to the absence of ICD-10-CM diagnosis code Z12.5 on the claim, use the ASC X12 835 claim adjustment reason code 167 – This (these) diagnosis(es) is (are) not covered.

RARC N386 – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

150 - Counseling to Prevent Tobacco Use

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

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

Note: *For claims effective 10/1/16. CPT Codes 99406 or 99407 used for processing NCD210.4.1*

NOTE: Instructions in sections 150 thru 150.4 are no longer valid.

Effective for claims with dates of service on and after August 25, 2010, the Centers for Medicare & Medicaid Services (CMS) will cover counseling to prevent tobacco use services for outpatient and hospitalized Medicare beneficiaries:

- Who use tobacco, regardless of whether they have signs or symptoms of tobacco- related disease;
- Who are competent and alert at the time that counseling is provided; and,
- Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations.

Conditions of Medicare Part A and Medicare Part B coverage for counseling to prevent tobacco use are located in the Medicare National Coverage Determinations (NCD) Manual, Publication 100-3, chapter1, section 210.4.1.

NOTE: *Effective 9/30/15, NCD210.4 has been deleted from Pub. 100-03 NCD Manual. See NCD210.4.1 for remaining NCD re: Counseling to Prevent Tobacco Use.*

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

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

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

The CMS has created two new CPT codes for billing for tobacco cessation counseling services to prevent tobacco use for those individuals who use tobacco but do not have signs or symptoms of tobacco-related disease.

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

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

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

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

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

Short descriptor: Tobacco-use counsel 3-10 min

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

Short descriptor: Tobacco-use counsel >10min

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

ICD-10-CM

ICD-10 CM Code	*Code Description*
F17.210	*Nicotine dependence, cigarettes, uncomplicated*
F17.211	*Nicotine dependence, cigarettes, in remission*

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

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

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

150.2 - A/B MACs (B) Billing Requirements

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

A/B MACs (B) shall pay for counseling to prevent tobacco use services billed with code G0436 or G0437 for dates of service on or after January 1, 2011. A/B MACs (B) shall pay for counseling services billed with code 99199 for dates of service performed on or after August 25, 2010 through December 31, 2010. The type of service (TOS) for each of the new codes is 1.

A/B MACs (B) pay for counseling services billed based on the Medicare Physician Fee Schedule (MPFS). Deductible and coinsurance apply for services performed on August 25, 2010, through December 31, 2010. For claims with dates of service on and after January 1, 2011, coinsurance and deductible do not apply on G0436 and G0437.

Physicians or qualified non-physician practitioners shall bill the A/B MACs (B) for counseling to prevent tobacco use services on Form CMS-1500 or an approved electronic format.

NOTE: The above G codes will not be active in MACs' systems until January 1, 2011. Therefore, MACs shall advise providers to use unlisted code 99199 to bill for counseling to prevent tobacco use services during the interim period of August 25, 2010, through December 31, 2010.

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

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

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

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

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

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

outpatient services is as follows:

Type of Facility	**Method of Payment**
Rural Health Centers (RHCs) TOB 71X/Federally Qualified Health Centers (FQHCs)TOB 77X	All-inclusive rate (AIR) for the encounter
Hospitals TOBs 12X and 13X	OPPS for hospitals subject to OPPS MPFS for hospitals not subject to OPPS
Indian Health Services (IHS) Hospitals TOB 13X	AIR for the encounter
Skilled Nursing Facilities (SNFs) TOBs 22X and 23X	Medicare Physician Fee Schedule (MPFS)
Home Health Agencies (HHAs) TOB 34X	MPFS
Critical Access Hospitals (CAHs) TOB 85X	Method I: Technical services are paid at 101% of reasonable cost. Method II: technical services are paid at 101% of reasonable cost, and Professional services are paid at 115% of the MPFS Data Base
IHS CAHs TOB 85X	Based on specific rate
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC). That is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

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

Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT codes 99406 (Smoking

and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively

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

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

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

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

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

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

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

RARC N386 –" This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

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

MSN 15.4: The information provided does not support the need for this service or item.

MSN Spanish Version: La información proporcionada no confirma la necesidad para este servicio o artículo

When denying claims for counseling to prevent tobacco use services and smoking and tobacco-use cessation counseling services that exceed a combined total of 8 sessions within a 12-month *period (99406, 99407), A/B MACs (A), (B), or (HHH) shall use the following messages:*

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

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

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

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

MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time."

MSN Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."

150.4 - Common Working File (CWF)

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

The Common Working File (CWF) shall edit for the frequency of service limitations of counseling to prevent tobacco use sessions and smoking and tobacco-use cessation counseling services (*99406, 99407)* rendered to a beneficiary for a combined total of 8 sessions within a 12-month period. The beneficiary may receive another 8 sessions during a second or subsequent year after 11 full months have passed since the first Medicare covered counseling session was performed. To start the count for the second or subsequent 12-month period, begin with the month after the month in which the first Medicare covered counseling session was performed and count until 11 full months have elapsed.

By entering the beneficiary's health insurance claim number (HICN), providers have the capability to view the number of sessions a beneficiary has received for this service via inquiry through CWF.

170.2 - Diagnosis Code Reporting

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

A claim that is submitted for screening chlamydia, gonorrhea, syphilis, and/or hepatitis B shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

a. For claims for screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant use the following *ICD-10-CM* diagnosis codes:

- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; and
- *And* any of
    - *Z72.89 - Other problems related to lifestyle, or*
    - *Z72.51 - High risk heterosexual behavior, or*
    - *Z72.52 - High risk homosexual behavior, or*
    - *Z72.53 - High risk bisexual behavior (These diagnosis codes are used to indicate high/increased risk for STIs).*

b. For claims for screening for syphilis in men at increased risk use the following ICD-*10-CM* diagnosis codes:

- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; and
- ***And*** any of
    - *Z72.89 - Other problems related to lifestyle, or*
    - *Z72.51 - High risk heterosexual behavior, or*
    - *Z72.52 - High risk homosexual behavior, or*
    - *Z72.53 - High risk bisexual behavior (These diagnosis codes are used to indicate high/increased risk for STIs).*

c. For claims for screening for chlamydia and gonorrhea in pregnant women at increased risk for STIs use the following *ICD-10-CM* diagnosis codes, if applicable*:*

- *Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission;* ***and*** *one of:*
    - *Z72.89 - Other problems related to lifestyle, or*
    - *Z72.51 - High risk heterosexual behavior, or*
    - *Z72.52 - High risk homosexual behavior, or*
    - *Z72.53 - High risk bisexual behavior (These diagnosis codes are used to indicate high/increased risk for STIs).*

and *also one of the following.*

Code	***Description***
Z34.00	*Encounter for supervision of normal first pregnancy, unspecified trimester*
Z34.01	*Encounter for supervision of normal first pregnancy, first trimester*

Code	*Description*
Z34.02	*Encounter for supervision of normal first pregnancy, second trimester*
Z34.03	*Encounter for supervision of normal first pregnancy, third trimester*
Z34.80	*Encounter for supervision of other normal pregnancy, unspecified trimester*
Z34.81	*Encounter for supervision of other normal pregnancy, first trimester*
Z34.82	*Encounter for supervision of other normal pregnancy, second trimester*
Z34.83	*Encounter for supervision of other normal pregnancy, third trimester*
Z34.90	*Encounter for supervision of normal pregnancy, unspecified, unspecified trimester*
Z34.91	*Encounter for supervision of normal pregnancy, unspecified, first trimester*
Z34.92	*Encounter for supervision of normal pregnancy, unspecified, second trimester*
Z34.93	*Encounter for supervision of normal pregnancy, unspecified, third trimester*
O09.90	*Supervision of high risk pregnancy, unspecified, unspecified trimester*
O09.91	*Supervision of high risk pregnancy, unspecified, first trimester*
O09.92	*Supervision of high risk pregnancy, unspecified, second trimester*
O09.93	*Supervision of high risk pregnancy, unspecified, third trimester*

d. For claims for screening for syphilis in pregnant women use the following ICD-10-CM diagnosis codes:

- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; and one of

Code	**Description**
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester

Code	Description
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

e. For claims for screening for syphilis in pregnant women at increased risk for STIs use the following ICD-10-CM diagnosis codes:

- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; **and** any of:
    - *Z72.89 - Other problems related to lifestyle, or*
    - *Z72.51 - High risk heterosexual behavior, or*
    - *Z72.52 - High risk homosexual behavior, or*
    - *Z72.53 - High risk bisexual behavior (These diagnosis codes are used to indicate high/increased risk for STIs).*

and also one of the following:

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

f. For claims for screening for hepatitis B in pregnant women use the following ICD-10-CM diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases, **and** any of
- Z34.00 - Encounter for supervision of normal first pregnancy, unspecified trimester, or
- Z34.80 - Encounter for supervision of other normal pregnancy, unspecified trimester, or
- Z34.90 - Encounter for supervision of normal pregnancy, unspecified, unspecified trimester, or
- O09.90 - Supervision of high risk pregnancy, unspecified, unspecified trimester.

g. For claims for screening for hepatitis B in pregnant women at increased risk for STIs use the following ICD-10 -CM diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases, and
- Z72.89 - Other problems related to lifestyle, **and**
- any of
  - Z72.51 - High risk heterosexual behavior, or
  - Z72.52 - High risk homosexual behavior, or
  - Z72.53 - High risk bisexual behavior*;*
- **and** also one of the following:

Code	***Description***
Z34.00	*Encounter for supervision of normal first pregnancy, unspecified trimester*
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

170.3 - Billing Requirements

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Effective for dates of service November 8, 2011, and later, A/B MACs (A) and (B) shall recognize HCPCS code G0445 for HIBC. Medicare shall cover up to two occurrences of G0445 when billed for HIBC to prevent STIs. A claim that is submitted with HCPCS code G0445 for HIBC shall be submitted *with ICD-10-CM diagnosis code Z72.89.*

A/B MACs (A) and (B) shall pay for screening for chlamydia, gonorrhea, and syphilis (as indicated by the presence *of ICD-10 is applicable, ICD-10-CM diagnosis code Z11.3; and/or hepatitis B (as indicated by the presence of ICD-10-CM diagnosis code Z11.59 as follows:*

- One annual occurrence of screening for chlamydia, gonorrhea, and syphilis (i.e., 1 per 12-month period) in women at increased risk who are not pregnant,
- One annual occurrence of screening for syphilis (i.e., 1 per 12-month period) in men at increased risk,
- Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening,
- One occurrence per pregnancy of screening for syphilis in pregnant women,
- Up to an additional two occurrences per pregnancy of screening for syphilis in pregnant women if the beneficiary is at continued increased risk for STIs,
- One occurrence per pregnancy of screening for hepatitis B in pregnant women, and,
- One additional occurrence per pregnancy of screening for hepatitis B in pregnant women who are at continued increased risk for STIs.

210.3 – Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Contractors shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for HCV screening, HCPCS G0472:

- Denying services submitted on a TOB other than 13X, 14X, or 85X:

  CARC 170 - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N95 – This provider type/provider specialty may not bill this service.

  MSN 21.25: This service was denied because Medicare only covers this service in certain settings.

  Spanish Version: “El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

  Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

Denying services where previous HCV screening, HCPCS G0472, is paid in history for claims with dates of service on and after June 2, 2014, and the patient is not deemed high risk by the presence of ICD-10 diagnosis code Z72.89, other problems related to lifestyle, and ICD-10 diagnosis code F19.20, other psychoactive substance dependence, uncomplicated:

CARC 119 – Benefit maximum for this time period or occurrence has been reached.

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

MSN 15.20 – The following policies NCD210.13 were used when we made this decision.

Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

MSN 15.19 - Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

NOTE: Due to system requirement, 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.

NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

NOTE: This edit shall be overridable.

Denying services for HCV screening, HCPCS G0472, for beneficiaries at high risk who have had continued illicit drug use since the prior negative screening test, when claims are not submitted with ICD-10 diagnosis code Z72.89, and ICD-10 diagnosis code F19.20, and/or 11 full months have not passed since the last negative HCV screening test:

CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

MSN 15.20: "The following policies [insert LMRP/LCD ID #(s) and NCD #(s)] were used when we made this decision.

Spanish Version - Las siguientes políticas [añadir los #s de LMRP/LCD, por sus siglas en inglés y los #s de NCD, por sus siglas en inglés] fueron utilizadas cuando se tomó esta decisión.

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

NOTE: This edit shall be overridable.

- Denying services for HCV screening, G0472, for beneficiaries who do not meet the definition of high risk, but who were born from 1945 through 1965, when claims are submitted more than once in a lifetime:

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

  RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

  MSN 15.20 – The following policies NCD210.13 were used when we made this decision.

  Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

  MSN 15.19 - Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD.

  Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

  NOTE: Due to system requirement, 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.

  Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

  NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

NOTE: This edit shall be overridable.

- Denying claim lines for HCV screening, G0472, without the appropriate POS code:

  CARC 171 – Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N428 - Not covered when performed in certain settings.

  MSN 21.25 - This service was denied because Medicare only covers this service in certain settings.

  Spanish Version: “El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

  Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

- Denying claim lines for HCV screening, G0472, that are not submitted from the appropriate provider specialties:

  CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N574 – Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.

MSN 21.18 - This item or service is not covered when performed or ordered by this provider.

Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50, Group Code CO, and MSN 8.81.

- Denying claim lines for HCV screening, HCPCS G0472, if beneficiary born prior to 1945 and after 1965 who are not at high risk (absence of ICD-10 diagnosis code Z72.89 or F19.20 *or Z11.59:*

  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 N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

  MSN 15.19 - Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from

your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD.

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20 – The following policies NCD210.13 were used when we made this decision.

Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

NOTE: Due to system requirement, 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.

Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

210.4 - Common Working File (CWF) Edits

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

The common working file (CWF) shall apply the following frequency limitations to HCV screening, HCPCS G0472:

One initial HCV screening, HCPCS G0472, for beneficiaries at high risk, when claims are submitted with ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented),

Annual HCV screening, HCPCS G0472, when claims are submitted with ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented), and ICD-9 diagnosis code 304.91/ICD-10 diagnosis code F19.20 (once ICD-10 is implemented),

Once in a lifetime HCV screening, HCPCS G0472, for beneficiaries who are not high risk who were born from 1945 through 1965.

NOTE: These edits shall be overridable.

NOTE: HCV screening, HCPCS G0472 is not a covered service for beneficiaries born prior to 1945 and after 1965 who are not at high risk (absence of ICD-10 diagnosis code Z72.89 and/or F19.20 *and/or Z11.59 ICD-10 diagnosis code.*

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

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(Rev.11161; Issued: 12-14-21)

10.1 - Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

A. Coding Applicable to A/B MACs (A and B)

Effective April 1, 2002, a National Coverage Decision was made to allow for Medicare coverage of ABPM for those beneficiaries with suspected "white coat hypertension" (WCH). ABPM involves the use of a non-invasive device, which is used to measure blood pressure in 24-hour cycles. These 24-hour measurements are stored in the device and are later interpreted by a physician. Suspected "WCH" is defined as: (1) Clinic/office blood pressure >140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit; (2) At least two documented separate blood pressure measurements taken outside the clinic/office which are < 140/90 mm Hg; and (3) No evidence of end-organ damage. ABPM is not covered for any other uses. Coverage policy can be found in Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §20.19. (http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp).

The ABPM must be performed for at least 24 hours to meet coverage criteria. Payment is not allowed for institutionalized beneficiaries, such as those receiving Medicare covered skilled nursing in a facility. In the rare circumstance that ABPM needs to be performed more than once for a beneficiary, the qualifying criteria described above must be met for each subsequent ABPM test.

Effective dates for applicable Common Procedure Coding System (HCPCS) codes for ABPM for suspected WCH and their covered effective dates are as follows:

HCPCS	Definition	Effective Date
93784	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report.	04/01/2002
93786	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only.	04/01/2002
93788	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.	01/01/2004

HCPCS	Definition	Effective Date
93790	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report.	04/01/2002

In addition, one of the following diagnosis codes must be present:

	Diagnosis Code	Description
If ICD-10-CM is applicable	*R03.0*	*Elevated blood pressure reading without diagnosis of hypertension*

B. A/B MAC (A) Billing Instructions

The applicable types of bills acceptable when billing for ABPM services are 13X, 23X, 71X, 73X, 75X, and 85X. Chapter 25 of this manual provides general billing instructions that must be followed for bills submitted to A/B MACs (A). The A/B MACs (A) pay for hospital outpatient ABPM services billed on a 13X type of bill with HCPCS 93786 and/or 93788 as follows: (1) Outpatient Prospective Payment System (OPPS) hospitals pay based on the Ambulatory Payment Classification (APC); (2) non-OPPS hospitals (Indian Health Services Hospitals, Hospitals that provide Part B services only, and hospitals located in American Samoa, Guam, Saipan and the Virgin Islands) pay based on reasonable cost, except for Maryland Hospitals which are paid based on a percentage of cost. Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for ABPM.

The A/B MACs (A) pay for comprehensive outpatient rehabilitation facility (CORF) ABPM services billed on a 75x type of bill with HCPCS code 93786 and/or 93788 based on the Medicare Physician Fee Schedule (MPFS) amount for that HCPCS code.

The A/B MACs (A) pay for ABPM services for critical access hospitals (CAHs) billed on a 85x type of bill as follows: (1) for CAHs that elected the Standard Method and billed HCPCS code 93786 and/or 93788, pay based on reasonable cost for that HCPCS code; and (2) for CAHs that elected the Optional Method and billed any combination of HCPCS codes 93786, 93788 and 93790 pay based on reasonable cost for HCPCS 93786 and 93788 and pay 115% of the MPFS amount for HCPCS 93790.

The A/B MACs (A) pay for ABPM services for skilled nursing facility (SNF) outpatients billed on a 23x type of bill with HCPCS code 93786 and/or 93788, based on the MPFS.

The A/B MACs (A) accept independent and provider-based rural health clinic (RHC) bills for visits under the all-inclusive rate when the RHC bills on a 71x type of bill with revenue code 052x for providing the professional component of ABPM services. The A/B MACs (A) should not make a separate payment to a RHC for the professional component of ABPM services in addition to the all-inclusive rate. RHCs are not required to use ABPM HCPCS codes for professional services covered under the all-inclusive rate.

The A/B MACs (A) accept free-standing and provider-based federally qualified health center (FQHC) bills for visits under the all-inclusive rate when the FQHC bills on a 73x type of bill with revenue code 052x for providing the professional component of ABPM services.

The A/B MACs (A) should not make a separate payment to a FQHC for the professional component of ABPM services in addition to the all-inclusive rate. FQHCs are not required to use ABPM HCPCS codes for professional services covered under the all-inclusive rate.

The A/B MACs (A) pay provider-based RHCs/FQHCs for the technical component of ABPM services when billed under the base provider's number using the above requirements for that particular base provider type, i.e., a OPPS hospital based RHC would be paid for the ABPM technical component services under the OPPS using the APC for code 93786 and/or 93788 when billed on a 13x type of bill.

Independent and free-standing RHC/FQHC practitioners are only paid for providing the technical component of ABPM services when billed to the A/B MAC (B) following the MAC's instructions.

- **A/B MAC (B) Claims**

A/B MACs (B) pay for ABPM services billed with *ICD-10-CM* diagnosis code *R03.0* (if ICD-*10* is applicable) and HCPCS codes 93784 or for any combination of 93786, 93788 and 93790, based on the MPFS for the specific HCPCS code billed.

- **Coinsurance and Deductible**

The A/B MACs (A and B) shall apply coinsurance and deductible to payments for ABPM services except for services billed to the A/B MAC (A) by FQHCs. For FQHCs only co-insurance applies.

30.1 - Billing Requirements for HBO Therapy for the Treatment of Diabetic Wounds of the Lower Extremities

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Hyperbaric Oxygen Therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. Effective April 1, 2003, a National Coverage Decision expanded the use of HBO therapy to include coverage for the treatment of diabetic wounds of the lower extremities. For specific coverage criteria for HBO Therapy, refer to the National Coverage Determinations Manual, Chapter 1, section 20.29.

NOTE: Topical application of oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no Medicare reimbursement may be made for the topical application of oxygen.

- **Billing Requirements for A/B MACs (A)**

Claims for HBO therapy should be submitted using the ASC X12 837 institutional claim format or, in rare cases, on Form CMS-1450.

a. Applicable Bill Types

The applicable hospital bill types are 11X, 13X and 85X.

b. Procedural Coding

- 99183 – Physician attendance and supervision of hyperbaric oxygen therapy, per session.

- *G0277 – Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval.*

NOTE: Code *G0277* is not available for use other than in a hospital outpatient department. In skilled nursing facilities (SNFs), HBO therapy is part of the SNF PPS payment for beneficiaries in covered Part A stays.

For hospital inpatients and critical access hospitals (CAHs) not electing Method I, HBO therapy is reported under revenue code 940 without any HCPCS code. *For inpatient services, if ICD-10 is applicable, show ICD-10-PCS code 5A05121.*

For CAHs electing Method I, HBO therapy is reported under revenue code 940 along with HCPCS code 99183.

c. Payment Requirements for A/B MACs (A)

Payment is as follows:

A/B MAC (A) payment is allowed for HBO therapy for diabetic wounds of the lower extremities when performed as a physician service in a hospital outpatient setting and for inpatients. Payment is allowed for claims with valid diagnosis codes as shown above with dates of service on or after April 1, 2003. Those claims with invalid codes should be denied as not medically necessary.

For hospitals, payment will be based upon the Ambulatory Payment Classification (APC) or the inpatient Diagnosis Related Group (DRG). Deductible and coinsurance apply.

Payment to Critical Access Hospitals (electing Method I) is made under cost reimbursement. For Critical Access Hospitals electing Method II, the technical component is paid under cost reimbursement and the professional component is paid under the Physician Fee Schedule.

II. A/B MAC (B) Billing Requirements

Claims for this service should be submitted using the ASC X12 837 professional claim format or Form CMS-1500.

The following HCPCS code applies:

- 99183 – Physician attendance and supervision of hyperbaric oxygen therapy, per session.

- *G0277 – Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval.*

a. Payment Requirements for A/B MACs (B)

Payment and pricing information will occur through updates to the Medicare Physician Fee Schedule Database (MPFSDB). Pay for this service on the basis of the MPFSDB. Deductible and coinsurance apply. Claims from physicians or other practitioners where assignment was not taken, are subject to the Medicare limiting charge.

III. Medicare Summary Notices (MSNs)

Use the following MSN Messages where appropriate:

In situations where the claim is being denied on the basis that the condition does not meet our coverage requirements, use one of the following MSN Messages:

> "Medicare does not pay for this item or service for this condition." (MSN Message 16.48)

The Spanish version of the MSN message should read:

> "Medicare no paga por este articulo o servicio para esta afeccion."

In situations where, based on the above utilization policy, medical review of the claim results in a determination that the service is not medically necessary, use the following MSN message:

> "The information provided does not support the need for this service or item." (MSN Message 15.4)

The Spanish version of the MSN message should read:

> "La informacion proporcionada no confirma la necesidad para este servicio o articulo."

IV. Remittance Advice Notices

Use appropriate existing remittance advice remark codes and claim adjustment reason codes at the line level to express the specific reason if you deny payment for HBO therapy for the treatment of diabetic wounds of lower extremities.

50.3.2– Bill Types

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Deep Brain Stimulation

may be submitted on

institutional claims

using the following

Types of Bill:

11X, 12X, 13X, and 85X

50.4.1– Allowable Covered Diagnosis Codes

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Deep Brain Stimulation is covered for the following diagnosis codes:

If ICD-10-CM is applicable:

- *ICD-10-CM G20 - Parkinson's Disease*
- *ICD-10-CM G25.0 - Essential tremor*
- *ICD-10-CM G25.2 - Other specified form of tremor*

50.4.2– Allowable Covered Procedure Codes

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

The following procedure codes may be present:

If ICD-10-PCS is applicable:

ICD-10-PCS Code	***Code Description***
00H00MZ	*Insertion of Neurostimulator Lead into Brain, Open Approach*
00H03MZ	Insertion of Neurostimulator Lead into Brain, Percutaneous Approach
00H04MZ	Insertion of Neurostimulator Lead into Brain, Endoscopic Approach
00H60MZ	Insertion of Neurostimulator Lead into Cerebral Ventricle, Open Approach
00H63MZ	Insertion of Neurostimulator Lead into Cerebral Ventricle, Percutaneous Approach
00H64MZ	Insertion of Neurostimulator Lead into Cerebral Ventricle, Percutaneous Endoscopic Approach
00P00MZ	*Removal of Neurostimulator Lead from Brain, Open Approach*
00P03MZ	*Removal of Neurostimulator Lead from Brain, Percutaneous Approach*
00P04MZ	*Removal of Neurostimulator Lead from Brain, Percutaneous Endoscopic Approach*
00P60MZ	*Removal of Neurostimulator Lead from Cerebral Ventricle, Open Approach*
00P63MZ	*Removal of Neurostimulator Lead from Cerebral Ventricle, Percutaneous Approach*
00P64MZ	*Removal of Neurostimulator Lead from Brain, Open Approach*
0H80XZZ	*Division of Scalp Skin, External Approach*
0HSSXZZ	*Reposition Hair, External Approach*

Coverage policy may be found in the National Coverage Determinations Manual in Chapter 1, section 160.24: Deep Brain Stimulation, using the following link: (http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp).

50.4.3 – Healthcare Common Procedure Coding System (HCPCS)

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

The following HCPCS codes are available for use when billing for covered deep brain stimulation:

61880 Revision or removal of intracranial neurostimulator electrodes

61885 Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

61886 Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays

61888 Revision or removal of cranial neurostimulator pulse generator or receiver

95961 Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance

95962 Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance (List separately in addition to code for primary procedure) (Use 95962 in conjunction with code 95961)

95970 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

95971 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple brain, spinal cord, or peripheral (i.e., peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming.

95983 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, doe lockout,

patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/ transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional.

95984 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, doe lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional.

60.12 - Coverage for PET Scans for Dementia and Neurodegenerative Diseases

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Effective for dates of service on or after September 15, 2004, Medicare will cover FDG PET scans for a differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease OR; its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases. Refer to Pub. 100-03, NCD Manual, section 220.6.13, for complete coverage conditions and clinical trial requirements and section 60.15 of this manual for claims processing information.

A. A/B MAC (A and B) Billing Requirements for PET Scan Claims for FDG-PET for the Differential Diagnosis of Fronto-temporal Dementia and Alzheimer's Disease:

CPT Code for PET Scans for Dementia and Neurodegenerative Diseases

Contractors shall advise providers to use the appropriate CPT code from section 60.3.1 for dementia and neurodegenerative diseases for services performed on or after January 28, 2005.

Diagnosis Codes for PET Scans for Dementia and Neurodegenerative Diseases

The contractor shall ensure one of the following appropriate diagnosis codes is present on claims for PET Scans for AD:

- *ICD-10-CM is applicable, ICD-10 codes are: F03.90, F03.90 plus F05, G30.9, G31.01, G31.9, R41.2 or R41.3*

Medicare contractors shall deny claims when submitted with an appropriate CPT code from section 60.3.1 and with a diagnosis code other than the range of codes listed above.

Medicare contractors shall instruct providers to issue an Advanced Beneficiary Notice to beneficiaries advising them of potential financial liability prior to delivering the service if one of the appropriate diagnosis codes will not be present on the claim.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR (if claim is received with a GA modifier) otherwise CO
CARC: 11
RARC: N/A
MSN: 16.48

Provider Documentation Required with the PET Scan Claim

Medicare contractors shall inform providers to ensure the conditions mentioned in the NCD Manual, section 220.6.13, have been met. The information must also be maintained in the beneficiary's medical record:

- Date of onset of symptoms;
- Diagnosis of clinical syndrome (normal aging, mild cognitive impairment or MCI: mild, moderate, or severe dementia);
- Mini mental status exam (MMSE) or similar test score;
- Presumptive cause (possible, probably, uncertain AD);
- Any neuropsychological testing performed;
- Results of any structural imaging (MRI, CT) performed;
- Relevant laboratory tests (B12, thyroid hormone); and,
- Number and name of prescribed medications.

B. Billing Requirements for Beta Amyloid Positron Emission Tomography (PET) in Dementia and Neurodegenerative Disease:

Effective for claims with dates of service on and after September 27, 2013, Medicare will only allow coverage with evidence development (CED) for Positron Emission Tomography (PET) beta amyloid (also referred to as amyloid-beta (Aβ)) imaging (HCPCS A9586*) or (HCPCS Q9982) or (HCPCS Q9983)* (one PET Aβ scan per patient).

Note: Please note that effective January 1, 2014 the following code A9599 will be updated in the IOCE and HCPCS update. This code will be contractor priced.

Note: Please note that effective January 1, 2018 the following code A9599 is end-date.

Medicare Summary Notices, Remittance Advice Remark Codes, and Claim Adjustment Reason Codes

Effective for dates of service on or after September 27, 2013, contractors shall **return as unprocessable/return to provider** claims for PET Aβ imaging, through CED during a clinical trial, not containing the following:

- Condition code 30*, and value code* D4 (FI only)
- *Modifier Q0 as appropriate*
- *CD-10* dx code *Z00.6 (in* either the primary/secondary position)
- A PET HCPCS code (78811 or78814)
- At least, one Dx code from the table below,

And one of these additional diagnoses is required in addition to Z00.6

F03.90	Unspecified dementia without behavioral disturbance
F03.91	Unspecified dementia with behavioral disturbance
F01.50	Vascular dementia without behavioral disturbance
F01.51	Vascular dementia with behavioral disturbance

F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
G31.01	Pick's disease
G31.09	Other frontotemporal dementia
G31.85	Corticobasal degeneration
G31.83	Dementia with Lewy bodies
G31.84	Mild cognitive impairment, so stated
R41.1	Anterograde amnesia
R41.2	Retrograde amnesia
R41.3	Other amnesia (amnesia NOS, memory loss NOS)

and

- Aβ HCPCS code A9586 or Q9982 or Q9983)

Contractors shall return as unprocessable claims for PET Aβ imaging using the following messages:

-Claim Adjustment Reason Code 4 – the procedure code is inconsistent with the modifier used or a required modifier is missing.

Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Remittance Advice Remark Code N519 - Invalid combination of HCPCS modifiers.

Contractors shall line-item **deny** claims for PET Aβ , HCPCS code A9586 *or Q9982 or Q9983,* where a previous PET Aβ, HCPCS code A9586 or *Q9982 or Q9983* is paid in history using the following messages:

- CARC 149: “Lifetime benefit maximum has been reached for this service/benefit category.”
- RARC N587: “Policy benefits have been exhausted”.
- MSN 20.12: “This service was denied because Medicare only covers this service once a lifetime.”
- Spanish Version: “Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida.”
- Group Code: PR, if a claim is received with a GA modifier
- Group Code: CO, if a claim is received with a GZ modifier

70.4- Special Billing and Payment Requirements for A/B MACs (A)

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

If ICD-10 is applicable, ICD-10-PCS codes for the clinical trial are:

ICD-10-PCS Code	**Code Description**
3E030U1	Introduction of Nonautologous Pancreatic Islet Cells into Peripheral Vein, Open Approach
3E033U1	Introduction of Nonautologous Pancreatic Islet Cells into Peripheral Vein, Percutaneous Approach
3E0J3U1	Introduction of Nonautologous Pancreatic Islet Cells into Biliary and Pancreatic Tract, Percutaneous Approach
3E0J7U1	Introduction of Nonautologous Pancreatic Islet Cells into Biliary and Pancreatic Tract, Via Natural or Artificial Opening
3E0J8U1	Introduction of Nonautologous Pancreatic Islet Cells into Biliary and Pancreatic Tract, Via Natural or Artificial Opening Endoscopic

If ICD-10 is applicable, ICD-10-CM codes for the clinical trial are:

E10.9	*Type 1 diabetes mellitus without complications*
E10.65	*Type 1 diabetes mellitus with hyperglycemia*
E10.10	*Type 1 diabetes mellitus with ketoacidosis without coma*
E10.69	*Type 1 diabetes mellitus with other specified complication*
E10.21	*Type 1 diabetes mellitus with diabetic nephropathy*
E10.22	*Type 1 diabetes mellitus with diabetic chronic kidney disease*
E10.29	*Type 1 diabetes mellitus with other diabetic kidney complication*
E10.311	*Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema*
E10.319	*Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema*
E10.3211	*Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye*
E10.3212	*Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye*
E10.3213	*Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral*
E10.3291	*Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye*
E10.3292	*Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye*
E10.3293	*Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral*
E10.3311	*Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye*
E10.3312	*Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye*
E10.3313	*Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral*
E10.3391	*Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye*
E10.3392	*Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye*
E10.3393	*Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral*
E10.3411	*Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye*
E10.3412	*Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye*
E10.3413	*Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral*
E10.3491	*Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye*
E10.3492	*Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye*
E10.3493	*Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral*
E10.3511	*Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye*
E10.3512	*Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye*
E10.3513	*Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral*

E10.3521 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E10.3522 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E10.3523 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E10.3531 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E10.3532 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E10.3533 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E10.3541 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E10.3542 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E10.3543 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E10.3551 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E10.3552 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E10.3553 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E10.3591 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E10.3592 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E10.3593 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E10.37x1 Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E10.37x2 Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E10.37x3 Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E10.36 Type 1 diabetes mellitus with diabetic cataract
E10.39 Type 1 diabetes mellitus with other diabetic ophthalmic complication
E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.41 Type 1 diabetes mellitus with diabetic mononeuropathy
E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43 Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
E10.44 Type 1 diabetes mellitus with diabetic amyotrophy
E10.49 Type 1 diabetes mellitus with other diabetic neurological complication
E10.610 Type 1 diabetes mellitus with diabetic neuropathic arthropathy
E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.52 Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.59 Type 1 diabetes mellitus with other circulatory complications
E10.618 Type 1 diabetes mellitus with other diabetic arthropathy
E10.620 Type 1 diabetes mellitus with diabetic dermatitis
E10.621 Type 1 diabetes mellitus with foot ulcer
E10.622 Type 1 diabetes mellitus with other skin ulcer
E10.628 Type 1 diabetes mellitus with other skin complications
E10.630 Type 1 diabetes mellitus with periodontal disease
E10.638 Type 1 diabetes mellitus with other oral complications
E10.649 Type 1 diabetes mellitus with hypoglycemia without coma
E10.8 Type 1 diabetes mellitus with unspecified complications

Secondary ICD-10-CM Diagnosis requirement for Clinical Trial:

Z00.6 Encounter for examination for normal comparison and control in clinical research program

The applicable TOB is 11X. A secondary diagnoses (diagnoses positions 2 – 9) *of ICD-10- CM code Z00.6 (*examination of participant or control in clinical research) must be present along with condition code 30 (qualifying clinical trial) *Z00.6 and condition code 30 alerts the claims processing system that this is a clinical trial. The procedure is paid under inpatient prospective payment system for hospitals with patients in the trial. Deductible and coinsurance apply for fee-for-service beneficiaries*.

Inpatient hospitals participating in this trial are entitled to an add-on payment of $18,848.00 for islet isolation services. This amount is in addition to the final IPPS payment made to the hospital. Should two infusions occur during the same hospital stay, Medicare will pay for two add-ons for isolation of the islet cells, but never for more than two add-ons for a hospital stay.

Inpatient hospitals shall report charges for organ acquisition in Revenue Code 0810, 0811, 0812, 0813, or 0819. This includes charges for the pre-transplant items and services related to the acquisition and delivery of the pancreatic islet cell transplants. As is Medicare's policy with other organ transplants, Medicare contractors deduct acquisition charges prior to processing through the IPPS Pricer. Pancreata procured for islet cell transplant are not included in the prospective payment. They are paid on a reasonable cost basis. This is a pass-through cost for which interim payments may be made.

Effective for services on or after May 1, 2006, contractors shall accept the QR modifier for islet cell transplantation follow up care when performed in an outpatient department of a hospital when the transplant was done in conjunction with an NIH-sponsored clinical trial, and when billed on type of bill 13X or 85X.

All other normal inpatient billing practices apply.

80.3- Diagnosis Codes

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

If ICD-10-CM is applicable–Providers should report one of the following diagnosis codes in conjunction with this benefit:

ICD-10-CM	***ICD-10 DX Description***
E08.40	*Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified*
E08.42	*Diabetes mellitus due to underlying condition with diabetic polyneuropathy*
E09.40	*Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified*
E09.42	*Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy*
E10.40	*Type 1 diabetes mellitus with diabetic neuropathy, unspecified*
E10.41	*Type 1 diabetes mellitus with diabetic mononeuropathy*
E10.42	*Type 1 diabetes mellitus with diabetic polyneuropathy*
E10.43	*Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy*
E10.44	*Type 1 diabetes mellitus with diabetic amyotrophy*
E10.49	*Type 1 diabetes mellitus with other diabetic neurological complication*
E10.610	*Type 1 diabetes mellitus with diabetic neuropathic arthropathy*
E11.40	*Type 2 diabetes mellitus with diabetic neuropathy, unspecified*
E11.41	*Type 2 diabetes mellitus with diabetic mononeuropathy*
E11.42	*Type 2 diabetes mellitus with diabetic polyneuropathy*

E11.43	*Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy*
E11.44	*Type 2 diabetes mellitus with diabetic amyotrophy*
E11.49	*Type 2 diabetes mellitus with other diabetic neurological complication*
E11.610	*Type 2 diabetes mellitus with diabetic neuropathic arthropathy*
E13.40	*Other specified diabetes mellitus with diabetic neuropathy, unspecified*
E13.41	*Other specified diabetes mellitus with diabetic mononeuropathy*
E13.42	*Other specified diabetes mellitus with diabetic polyneuropathy*
E13.43	*Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy*
E13.44	*Other specified diabetes mellitus with diabetic amyotrophy*
E13.49	*Other specified diabetes mellitus with other diabetic neurological complication*
E13.610	*Other specified diabetes mellitus with diabetic neuropathic arthropathy*

Coverage policy can be found in Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, section 70.2.1 Diabetic neuropathy w/ LOPs. (http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp

80.6 - Editing Instructions for A/B MACs (A)

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Edit 1 - Implement diagnosis to procedure code edits to allow payment only for the LOPS codes, G0245, G0246, and G0247 when submitted with one of the following ICD-10-CM diagnosis codes

If ICD-10-CM is applicable:

ICD-10-CM	***ICD-10 DX Description***
E08.40	*Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified*
E08.42	*Diabetes mellitus due to underlying condition with diabetic polyneuropathy*
E09.40	*Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified*
E09.42	*Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy*
E10.40	*Type 1 diabetes mellitus with diabetic neuropathy, unspecified*
E10.41	*Type 1 diabetes mellitus with diabetic mononeuropathy*
E10.42	*Type 1 diabetes mellitus with diabetic polyneuropathy*
E10.43	*Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy*
E10.44	*Type 1 diabetes mellitus with diabetic amyotrophy*
E10.49	*Type 1 diabetes mellitus with other diabetic neurological complication*
E10.610	*Type 1 diabetes mellitus with diabetic neuropathic arthropathy*
E11.40	*Type 2 diabetes mellitus with diabetic neuropathy, unspecified*
E11.41	*Type 2 diabetes mellitus with diabetic mononeuropathy*
E11.42	*Type 2 diabetes mellitus with diabetic polyneuropathy*
E11.43	*Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy*
E11.44	*Type 2 diabetes mellitus with diabetic amyotrophy*
E11.49	*Type 2 diabetes mellitus with other diabetic neurological complication*
E11.610	*Type 2 diabetes mellitus with diabetic neuropathic arthropathy*
E13.40	*Other specified diabetes mellitus with diabetic neuropathy, unspecified*
E13.41	*Other specified diabetes mellitus with diabetic mononeuropathy*

E13.42 Other specified diabetes mellitus with diabetic polyneuropathy
E13.43 Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy
E13.44 Other specified diabetes mellitus with diabetic amyotrophy
E13.49 Other specified diabetes mellitus with other diabetic neurological complication
E13.610 Other specified diabetes mellitus with diabetic neuropathic arthropathy

Deny these services when submitted without one of the appropriate diagnoses. Use the same messages you currently use for procedure to diagnosis code denials. Edit 2 – Deny G0247 if it is not submitted on the same claim as G0245 or G0246.

Use MSN 21.21 - This service was denied because Medicare only covers this service under certain circumstances.
Use RA claim adjustment reason code 107 - The related or qualifying claim/service was not identified on this claim. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

140.4.2.1 – Correct Place of Service (POS) Code for PR Services on Professional Claims

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Effective for claims with dates of service on and after January 1, 2010, place of service (POS) code 11 shall be used for pulmonary rehabilitation (PR) services provided in a physician's office and POS 22 shall be used for services provided in a hospital outpatient setting. All other POS codes shall be denied. Medicare contractors shall adjust their prepayment procedure edits as appropriate.

The following messages shall be used when Medicare contractors deny PR claims for POS:

CARC *96: "Non-covered charge(s)."*

RARC N428: "Service/procedure not covered when performed in this place of service."

Medicare Summary Notice (MSN) 21.25: "This service was denied because Medicare only covers this service in certain settings."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

NOTE: This is a new MSN message.

Contractors shall use Group Code PR (Patient `Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Contractors shall use Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

140.4.2.2 – Requirements for PR Services on Institutional Claims

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Effective for claims with dates of service on and after January 1, 2010, Medicare contractors shall pay for PR services when submitted on a type of bill (TOB) 13X and 85X only, along with revenue code 0948. All other TOBs shall be denied.

The following messages shall be used when Medicare contractors deny PR claims for TOB:

CARC *96: "Non-covered charge(s)."*

RARC N428: "Service/procedure not covered when performed in this place of service."

Medicare Summary Notice (MSN) 21.25: "This service was denied because Medicare only covers this service in certain settings."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

NOTE: This is a new MSN message.

Contractors shall use Group Code PR (Patient `Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Contractors shall use Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

140.4.2.5 – Edits for PR Services Exceeding 72 Sessions

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Effective for claims with dates of service on and after January 1, 2010, CWF shall reject PR claims that exceed 72 sessions. Medicare contractors shall deny PR claims that exceed 72 sessions regardless of whether the KX modifier is submitted on the claim line.

The following messages shall be used when Medicare contractors deny PR claims that exceed 72 sessions:

CARC *273*: "Coverage/program guidelines were exceeded."

MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time."

Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."

Contractors shall use Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Contractors shall use Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

150.3 - ICD Procedure Codes for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (A/MACs only)

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Covered ICD Procedure Codes

For services on or after October 1, 2015, the following independent ICD-10 procedure codes are covered for bariatric surgery:

0D16479	*Bypass Stomach to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach*
0D1647A	*Bypass Stomach to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach*
0D1647B	*Bypass Stomach to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach*
0D1647L	*Bypass Stomach to Transverse Colon with Autologous Tissue Substitute, Percutaneous Endoscopic Approach*
0D164J9	*Bypass Stomach to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach*
0D164JA	*Bypass Stomach to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach*
0D164JB	*Bypass Stomach to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach*
0D164JL	*Bypass Stomach to Transverse Colon with Synthetic Substitute, Percutaneous Endoscopic Approach*
0D164K9	*Bypass Stomach to Duodenum with Non-autologous Tissue Substitute, Percutaneous Endoscopic Approach*
0D164KA	*Bypass Stomach to Jejunum with Non-autologous Tissue Substitute, Percutaneous Endoscopic Approach*
0D164KB	*Bypass Stomach to Ileum with Non-autologous Tissue Substitute, Percutaneous Endoscopic Approach*
0D164KL	*Bypass Stomach to Transverse Colon with Non-autologous Tissue Substitute, Percutaneous Endoscopic Approach*
0D164Z9	*Bypass Stomach to Duodenum, Percutaneous Endoscopic Approach*
0D164ZA	*Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach*
0D164ZB	*Bypass Stomach to Ileum, Percutaneous Endoscopic Approach*
0D164ZL	*Bypass Stomach to Transverse Colon, Percutaneous Endoscopic Approach*

0D16079 *Bypass Stomach to Duodenum with Autologous Tissue Substitute, Open Approach*

0D1607A *Bypass Stomach to Jejunum with Autologous Tissue Substitute, Open Approach*

0D1607B *Bypass Stomach to Ileum with Autologous Tissue Substitute, Open Approach*

0D1607L *Bypass Stomach to Transverse Colon with Autologous Tissue Substitute, Open Approach*

0D160J9 *Bypass Stomach to Duodenum with Synthetic Substitute, Open Approach*

0D160JA *Bypass Stomach to Jejunum with Synthetic Substitute, Open Approach*

0D160JB *Bypass Stomach to Ileum with Synthetic Substitute, Open Approach*

0D160JL *Bypass Stomach to Transverse Colon with Synthetic Substitute, Open Approach*

0D160K9 *Bypass Stomach to Duodenum with Non-autologous Tissue Substitute, Open Approach*

0D160KA *Bypass Stomach to Jejunum with Non-autologous Tissue Substitute, Open Approach*

0D160KB *Bypass Stomach to Ileum with Non-autologous Tissue Substitute, Open Approach*

0D160KL *Bypass Stomach to Transverse Colon with Non-autologous Tissue Substitute, Open Approach*

0D160Z9 *Bypass Stomach to Duodenum, Open Approach*

0D160ZA *Bypass Stomach to Jejunum, Open Approach*

0D160ZB *Bypass Stomach to Ileum, Open Approach*

0D160ZL *Bypass Stomach to Transverse Colon, Open Approach*

0D16879 *Bypass Stomach to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D1687A *Bypass Stomach to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D1687B *Bypass Stomach to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D1687L *Bypass Stomach to Transverse Colon with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D168J9 *Bypass Stomach to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic*

0D168JA *Bypass Stomach to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic*

0D168JB *Bypass Stomach to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic*

0D168JL *Bypass Stomach to Transverse Colon with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic*

0D168K9 *Bypass Stomach to Duodenum with Non-autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D168KA *Bypass Stomach to Jejunum with Non-autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D168KB *Bypass Stomach to Ileum with Non-autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D168KL *Bypass Stomach to Transverse Colon with Non-autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D168Z9 *Bypass Stomach to Duodenum, Via Natural or Artificial Opening Endoscopic*

0D168ZA *Bypass Stomach to Jejunum, Via Natural or Artificial Opening Endoscopic*

0D168ZB *Bypass Stomach to Ileum, Via Natural or Artificial Opening Endoscopic*

0D168ZL Bypass Stomach to Transverse Colon, Via Natural or Artificial Opening Endoscopic

0DV64CZ Restriction of Stomach with Extraluminal Device, Percutaneous Endoscopic Approach

To describe either laparoscopic or open BPD with DS or GRDS, one code from each of the following three groups must be on the claim:

Group 1:

0DB60Z3	*Excision of Stomach, Open Approach, Vertical*
0DB60ZZ	*Excision of Stomach, Open Approach*
0DB63Z3	*Excision of Stomach, Percutaneous Approach, Vertical*
0DB63ZZ	*Excision of Stomach, Percutaneous Approach*
0DB67Z3	*Excision of Stomach, Via Natural or Artificial Opening, Vertical*
0DB67ZZ	*Excision of Stomach, Via Natural or Artificial Opening*
0DB68Z3	*Excision of Stomach, Via Natural or Artificial Opening Endoscopic, Vertical*

Group 2:

(Note: One code from A-C below is required for a correct equivalent)

0DB80ZZ	*Excision of Small Intestine, Open Approach – A*
0DB90ZZ	*Excision of Duodenum, Open Approach – A*
0DBB0ZZ	*Excision of Ileum, Open Approach – A*
0D160ZB	*Bypass Stomach to Ileum, Open Approach – B*
0F190Z3	*Bypass Common Bile Duct to Duodenum, Open Approach – C*

Group 3:

0D19079	*Bypass Duodenum to Duodenum with Autologous Tissue Substitute, Open Approach*
0D1907A	*Bypass Duodenum to Jejunum with Autologous Tissue Substitute, Open Approach*
0D1907B	*Bypass Duodenum to Ileum with Autologous Tissue Substitute, Open Approach*
0D190J9	*Bypass Duodenum to Duodenum with Synthetic Substitute, Open Approach*
0D190JA	*Bypass Duodenum to Jejunum with Synthetic Substitute, Open Approach*
0D190JB	*Bypass Duodenum to Ileum with Synthetic Substitute, Open Approach*
0D190K9	*Bypass Duodenum to Duodenum with Non-autologous Tissue Substitute, Open Approach*
0D190KA	*Bypass Duodenum to Jejunum with Non-autologous Tissue Substitute, Open Approach*
0D190KB	*Bypass Duodenum to Ileum with Non-autologous Tissue Substitute, Open Approach*
0D190Z9	*Bypass Duodenum to Duodenum, Open Approach*
0D190ZA	*Bypass Duodenum to Jejunum, Open Approach*
0D190ZB	*Bypass Duodenum to Ileum, Open Approach*
0D19479	*Bypass Duodenum to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D1947A *Bypass Duodenum to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D1947B *Bypass Duodenum to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D194J9 *Bypass Duodenum to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach*

0D194JA *Bypass Duodenum to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach*

0D194JB *Bypass Duodenum to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach*

0D194K9 *Bypass Duodenum to Duodenum with Non-autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D194KA *Bypass Duodenum to Jejunum with Non-autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D194KB *Bypass Duodenum to Ileum with Non-autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D194Z9 *Bypass Duodenum to Duodenum, Percutaneous Endoscopic Approach*

0D194ZA *Bypass Duodenum to Jejunum, Percutaneous Endoscopic Approach*

0D194ZB *Bypass Duodenum to Ileum, Percutaneous Endoscopic Approach*

0D19879 *Bypass Duodenum to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D1987A *Bypass Duodenum to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D1987B *Bypass Duodenum to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D198J9 *Bypass Duodenum to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic*

0D198JA *Bypass Duodenum to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic*

0D198JB *Bypass Duodenum to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic*

0D198K9 *Bypass Duodenum to Duodenum with Non-autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D198KA *Bypass Duodenum to Jejunum with Non-autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D198KB *Bypass Duodenum to Ileum with Non-autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D198Z9 *Bypass Duodenum to Duodenum, Via Natural or Artificial Opening Endoscopic*

0D198ZA *Bypass Duodenum to Jejunum, Via Natural or Artificial Opening Endoscopic*

0D198ZB *Bypass Duodenum to Ileum, Via Natural or Artificial Opening Endoscopic*

0D1A07A *Bypass Jejunum to Jejunum with Autologous Tissue Substitute, Open Approach*

0D1A07B *Bypass Jejunum to Ileum with Autologous Tissue Substitute, Open Approach*

0D1A0JA *Bypass Jejunum to Jejunum with Synthetic Substitute, Open Approach*

0D1A0JB *Bypass Jejunum to Ileum with Synthetic Substitute, Open Approach*

0D1A0KA *Bypass Jejunum to Jejunum with Non-autologous Tissue Substitute, Open Approach*

0D1A0KB *Bypass Jejunum to Ileum with Non-autologous Tissue Substitute, Open Approach*

0D1A0ZA *Bypass Jejunum to Jejunum, Open Approach*

0D1A0ZB *Bypass Jejunum to Ileum, Open Approach*

0D1A47A *Bypass Jejunum to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D1A47B *Bypass Jejunum to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D1A4JA *Bypass Jejunum to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach*

0D1A4JB *Bypass Jejunum to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach*

0D1A4KA *Bypass Jejunum to Jejunum with Non-autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D1A4KB *Bypass Jejunum to Ileum with Non-autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D1A4ZA *Bypass Jejunum to Jejunum, Percutaneous Endoscopic Approach*

0D1A4ZB *Bypass Jejunum to Ileum, Percutaneous Endoscopic Approach*

0D1A87A *Bypass Jejunum to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D1A87B *Bypass Jejunum to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D1A8JA *Bypass Jejunum to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic*

0D1A8JB *Bypass Jejunum to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic*

0D1A8KA *Bypass Jejunum to Jejunum with Non-autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D1A8KB *Bypass Jejunum to Ileum with Non-autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D1A8ZA *Bypass Jejunum to Jejunum, Via Natural or Artificial Opening Endoscopic*

0D1A8ZB *Bypass Jejunum to Ileum, Via Natural or Artificial Opening Endoscopic*

0D1A8ZH *Bypass Jejunum to Cecum, Via Natural or Artificial Opening Endoscopic*

0D1B07B *Bypass Ileum to Ileum with Autologous Tissue Substitute, Open Approach*

0D1B0JB *Bypass Ileum to Ileum with Synthetic Substitute, Open Approach*

0D1B0KB *Bypass Ileum to Ileum with Non-autologous Tissue Substitute, Open Approach*

0D1B0ZB *Bypass Ileum to Ileum, Open Approach*

0D1B47B *Bypass Ileum to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D1B4JB *Bypass Ileum to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach*

0D1B4KB *Bypass Ileum to Ileum with Non-autologous Tissue Substitute, Percutaneous Endoscopic Approach*

0D1B4ZB *Bypass Ileum to Ileum, Percutaneous Endoscopic Approach*

0D1B87B *Bypass Ileum to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic*

0D1B8JB *Bypass Ileum to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic*

0D1B8KB Bypass Ileum to Ileum with Non-autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic

0D1B8ZB Bypass Ileum to Ileum, Via Natural or Artificial Opening Endoscopic

0D1B8ZH Bypass Ileum to Cecum, Via Natural or Artificial Opening Endoscopic

NOTE: There is no distinction between open and laparoscopic BPD with DS or GRDS for the inpatient setting. For either approach, one code from each of the above three groups must appear on the claim to be covered.

Effective *October 1, 2015, the following ICD-10 procedure code is covered for bariatric surgery at contractor discretion:*

0DB64Z3 Excision of stomach, percutaneous endoscopic approach, vertical

150.4 - ICD Diagnosis Codes for Bariatric Surgery

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

For services on or after *October 1, 2015,* the following ICD-10 diagnosis code is covered for bariatric surgery if certain other conditions are met:

E66.01 - Morbid (severe) obesity due to excess calories

Effective for services performed on and after February 12, 2009, type 2 diabetes mellitus (T2DM) is considered a comorbid condition related to morbid obesity for covered bariatric surgery procedures in Medicare beneficiaries with a BMI ≥35. When T2DM is the comorbid condition related to morbid obesity, the claim must include a covered ICD procedure code, ICD diagnosis code *E66.01* as a primary diagnosis, a covered ICD diagnosis code indicating T2DM as a secondary diagnosis, and an ICD diagnosis code indicating a BMI ≥ 35 as a secondary diagnosis.

150.5 - ICD Diagnosis Codes for BMI ≥35

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

The following ICD-*10* diagnosis codes identify BMI ≥35:

Z68.35 - Body Mass Index 35.0-35.9, adult
Z68.36 - Body Mass Index 36.0-36.9, adult
Z68.37 - Body Mass Index 37.0-37.9, adult
Z68.38 - Body Mass Index 38.0-38.9, adult
Z68.39 - Body Mass Index 39.0-39.9, adult
Z68.41 - Body Mass Index 40.0-44.9, adult
Z68.42 - Body Mass Index 45.0-49.9, adult
Z68.43 - Body Mass Index 50.0-59.9, adult
Z68.44 - Body Mass Index 60.0-69.9, adult
Z68.45 - Body Mass Index 70.0 and over, adult

150.5.1 – ICD Codes for Type II Diabetes Mellitus Complication

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

E11.9	*Type 2 diabetes mellitus without complications*
E13.9	*Other specified diabetes mellitus without complications*
E11.65	*Type 2 diabetes mellitus with hyperglycemia*

E13.10	*Other specified diabetes mellitus with ketoacidosis without coma*
E11.69	*Type 2 diabetes mellitus with other specified complication*
	Note: E11.69 with E11.65 are a cluster BUT since each code on its own justifies the service, the combination is not required together for this policy.
E11.00	*Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)*
E11.01	*Type 2 diabetes mellitus with hyperosmolarity with coma*
E13.00	*Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)*
E13.01	*Other specified diabetes mellitus with hyperosmolarity with coma*
	Note: E11.00 with E11.65 are a cluster BUT since each code on its own justifies the service, the combination is not required together for this policy.
E11.641	*Type 2 diabetes mellitus with hypoglycemia with coma*
E13.11	*Other specified diabetes mellitus with ketoacidosis with coma*
E13.641	*Other specified diabetes mellitus with hypoglycemia with coma*
	Note: E11.01 with E11.65 are a cluster BUT since each code on its own justifies the service, the combination is not required together for this policy.
E11.21	*Type 2 diabetes mellitus with diabetic nephropathy*
E11.22	*Type 2 diabetes mellitus with diabetic chronic kidney disease*
E11.29	*Type 2 diabetes mellitus with other diabetic kidney complication*
E13.21	*Other specified diabetes mellitus with diabetic nephropathy*
E13.22	*Other specified diabetes mellitus with diabetic chronic kidney disease*
E13.29	*Other specified diabetes mellitus with other diabetic kidney complication*
	Note: E11.21 with E11.65 are a cluster BUT since each code on its own justifies the service, the combination is not required together for this policy.
E11.3211	*Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye*
E11.3212	*Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye*
E11.3213	*Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral*
E11.3591	*Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye*
E11.3592	*Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye*
E11.3593	*Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral*
E11.37X1	*Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye*
E11.37X2	*Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye*
E11.37X3	*Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral*
E11.3291	*Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye*
E11.3292	*Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye*
E11.3293	*Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral*
E11.3311	*Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye*
E11.3312	*Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye*

E11.3313	*Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral*
E11.3391	*Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye*
E11.3392	*Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye*
E11.3393	*Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral*
E11.3411	*Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye*
E11.3412	*Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye*
E11.3413	*Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral*
E11.3491	*Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye*
E11.3492	*Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye*
E11.3493	*Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral*
E11.3511	*Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye*
E11.3512	*Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye*
E11.3513	*Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral*
E11.3521	*Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye*
E11.3522	*Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye*
E11.3523	*Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral*
E11.3531	*Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye*
E11.3532	*Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye*
E11.3533	*Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral*
E11.3591	*Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye*
E11.3592	*Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye*
E11.3593	*Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral*
E11.37X1	*Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye*
E11.37X2	*Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye*
E11.37X3	*Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral*
E13.311	*Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema*
E13.319	*Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema*

E13.3211	*Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye*
E13.3212	*Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye*
E13.3213	*Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral*
E13.3291	*Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye*
E13.3292	*Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye*
E13.3293	*Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral*
E13.3311	*Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye*
E13.3312	*Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye*
E13.3313	*Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral*
E13.3391	*Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye*
E13.3392	*Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye*
E13.3393	*Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral*
E13.3411	*Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye*
E13.3412	*Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye*
E13.3413	*Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral*
E13.3491	*Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye*
E13.3492	*Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye*
E13.3493	*Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral*
E13.3511	*Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye*
E13.3512	*Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye*
E13.3513	*Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral*
E13.3521	*Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye*
E13.3522	*Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye*
E13.3523	*Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral*
E13.3531	*Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye*
E13.3532	*Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye*
E13.3533	*Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral*

E13.3541	*Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye*
E13.3542	*Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye*
E13.3543	*Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral*
E13.3551	*Other specified diabetes mellitus with stable proliferative diabetic retinopathy, right eye*
E13.3552	*Other specified diabetes mellitus with stable proliferative diabetic retinopathy, left eye*
E13.3553	*Other specified diabetes mellitus with stable proliferative diabetic retinopathy, bilateral*
E13.3591	*Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye*
E13.3592	*Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye*
E13.3593	*Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral*
E13.36	*Other specified diabetes mellitus with diabetic cataract*
E13.39	*Other specified diabetes mellitus with other diabetic ophthalmic complication*
E11.311	*Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema OR*
E11.319	*Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema OR*
E11.36	*Type 2 diabetes mellitus with diabetic cataract OR*
E11.39	*Type 2 diabetes mellitus with other diabetic ophthalmic complication AND*
	Note: E11.39 with E11.65 are a cluster BUT since each code on its own justifies the service, the combination is not required together for this policy
E13.37X1	*Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye*
E13.37X2	*Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye*
E13.37X3	*Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral*
E11.40	*Type 2 diabetes mellitus with diabetic neuropathy, unspecified*
E11.41	*Type 2 diabetes mellitus with diabetic mononeuropathy*
E11.42	*Type 2 diabetes mellitus with diabetic polyneuropathy*
E11.43	*Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy*
E11.44	*Type 2 diabetes mellitus with diabetic amyotrophy*
E11.49	*Type 2 diabetes mellitus with other diabetic neurological complication*
E11.610	*Type 2 diabetes mellitus with diabetic neuropathic arthropathy*
E13.40	*Other specified diabetes mellitus with diabetic neuropathy, unspecified*
E13.41	*Other specified diabetes mellitus with diabetic mononeuropathy*
E13.42	*Other specified diabetes mellitus with diabetic polyneuropathy*
E13.43	*Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy*
E13.44	*Other specified diabetes mellitus with diabetic amyotrophy*
E13.49	*Other specified diabetes mellitus with other diabetic neurological complication*
E13.610	*Other specified diabetes mellitus with diabetic neuropathic arthropathy*
	Note: E11.40 with E11.65 are a cluster BUT since each code on its own justifies the service, the combination is not required together for this policy.

E11.51	*Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene*
E11.52	*Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene*
E11.59	*Type 2 diabetes mellitus with other circulatory complications*
E13.51	*Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene*
E13.52	*Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene*
E13.59	*Other specified diabetes mellitus with other circulatory complications*
	Note: E11.51 with E11.65 are a cluster BUT since each code on its own justifies the service, the combination is not required together for this policy.
E11.618	*Type 2 diabetes mellitus with other diabetic arthropathy*
E11.620	*Type 2 diabetes mellitus with diabetic dermatitis*
E11.621	*Type 2 diabetes mellitus with foot ulcer*
E11.622	*Type 2 diabetes mellitus with other skin ulcer*
E11.628	*Type 2 diabetes mellitus with other skin complications*
E11.630	*Type 2 diabetes mellitus with periodontal disease*
E11.638	*Type 2 diabetes mellitus with other oral complications*
E11.649	*Type 2 diabetes mellitus with hypoglycemia without coma*
E13.618	*Other specified diabetes mellitus with other diabetic arthropathy*
E13.620	*Other specified diabetes mellitus with diabetic dermatitis*
E13.621	*Other specified diabetes mellitus with foot ulcer*
E13.622	*Other specified diabetes mellitus with other skin ulcer*
E13.628	*Other specified diabetes mellitus with other skin complications*
E13.630	*Other specified diabetes mellitus with periodontal disease*
E13.638	*Other specified diabetes mellitus with other oral complications*
E13.649	*Other specified diabetes mellitus with hypoglycemia without coma*
E13.65	*Other specified diabetes mellitus with hyperglycemia*
E13.69	*Other specified diabetes mellitus with other specified complication*
	Note: E11.69 with E11.65 are a cluster BUT since each code on its own justifies the service, the combination is not required together for this policy.
E13.8	*Other specified diabetes mellitus with unspecified complications*
E11.8	*Type 2 diabetes mellitus with unspecified complications*
	Note: E11.8 with E11.65 are a cluster BUT since each code on its own justifies the service, the combination is not required together for this policy.

150.6 - Claims Guidance for Payment

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Covered Bariatric Surgery Procedures for Treatment of Co-Morbid Conditions Related to Morbid Obesity

Contractors shall process covered bariatric surgery claims as follows:

C. Identify bariatric surgery claims.

Contractors identify inpatient bariatric surgery claims by the presence of ICD-10 diagnosis code E66.01as the primary diagnosis (for morbid obesity) and one of the covered ICD-10 procedure codes listed in §150.3.

Contractors identify practitioner bariatric surgery claims by the presence of ICD-10 diagnosis code E66.01 as the primary diagnosis (for morbid obesity) and one of the covered HCPCS procedure codes listed in §150.2.

D.Perform facility certification validation for all bariatric surgery claims on a pre-pay basis up to and including date of service September 23, 2013.

A list of approved facilities are found at the link noted in section 150.1, section A, above.

E. *Review bariatric surgery claims data and determine whether a pre- or post-pay sample of bariatric surgery claims need further review to assure that the beneficiary has a BMI ≥35 (Z68.35-Z68.45) (see ICD-10 equivalents above in section 150.5), and at least one co-morbidity related to obesity.*

The A/B MAC medical director may define the appropriate method for addressing the obesity-related co-morbid requirement.

Effective for dates of service on and after September 24, 2013, CMS has removed the certified facility requirements for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity.

NOTE: *If ICD-10 diagnosis code E66.01 is present,* but a covered procedure code (listed in §150.2 or §150.3) is/are not present, the claim is not for bariatric surgery and should be processed under normal procedures.

NOTE: *If ICD-10 diagnosis code E66.01 is present,* but a covered procedure code (listed in §150.2 or §150.3) is/are not present, the claim is not for bariatric surgery and should be processed under normal procedures.

150.7- Medicare Summary Notices (MSNs) and Claim Adjustment Reason Codes

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

When rejecting/denying claims because bariatric surgery procedures were performed in an unapproved facility use:

- MSN 16.2 - "This service cannot be paid when provided in this location/facility."

- Claim Adjustment Reason Code 58 - "Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."
- *Remittance Advice Remark Code N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."*

When rejecting/denying claims for non-covered bariatric surgery procedures use:

- MSN16.10 - Medicare does not pay for this item or service.

- Claim Adjustment Reason Code 50 - "These are non-covered services because this is not deemed a "medical necessity" by the payer."
- *Remittance Advice Remark Code N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at*

www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

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When rejecting/denying claims for covered bariatric surgery procedures because the patient did not meet the conditions for coverage use:

- MSN 15.4 - "The information provided does not support the need for this service or item."
- Claim Adjustment Reason Code 167 - "This (these) diagnosis(es) is (are) not covered"
- Remittance Advice Remark Code N*386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."*
- Group Code CO – Contractual Obligation

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

160.2.1 – Carotid Artery Stenting (CAS) for Post-Approval Studies

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

A. Background

As the post-approval studies began to end, CMS received requests to extend coverage for the post-approval studies. CMS has reviewed the extension requests and has determined that patients participating in post-approval extension studies are also included in the currently covered population of patients participating in FDA-approved post-approval studies.

B. Policy

To grant approval for post-approval studies, the FDA reviews each study protocol. Once approval is granted, the FDA issues a formal approval letter to the study sponsor.
Extensions of post-approval studies are not subject to approval by the FDA because they surpass the post-approval study requirements identified in the conditions of approval for post-approval studies. Since the FDA cannot approve these extension studies, individual Post-Market Approval (PMA) numbers cannot be issued to separately identify each study. Currently, in order to receive reimbursement for procedures performed as part of a carotid artery stenting post-approval study, providers must include the FDA-issued PMA number on each claim to indicate participation in a specific study.

CMS has determined that all extension studies must be reviewed by the FDA. The FDA will issue an acknowledgement letter stating that the extension study is scientifically valid and will generate clinically relevant post-market data. Upon receipt of this letter and review of the extension study protocol, CMS will issue a letter to the study sponsor indicating that the study under review will be covered by Medicare. Since an individual PMA number cannot be assigned by the FDA to each extension study, these studies will use the PMA number assigned to the original FDA-approved post-approval study (i.e., CAPTURE 2 shall use the PMA number assigned to CAPTURE 1).

C. Billing

In order to receive Medicare coverage for patients participating in post-approval extension studies, providers shall submit both the FDA acknowledgement letter and the CMS letter providing coverage for

the extension study to their contractor. Additionally, providers shall submit any other materials contractors would require for FDA-approved post- approval studies.

In response, contractors will issue a letter assigning an effective date for each facility's participation in the extension study. Providers may bill for procedures performed in the extension study for dates of service on and after the assigned effective date. Providers billing A/B MACs (A) must bill using the most current ICD-10-CM is applicable*, Indications for PTA of the Carotid Artery Concurrent with Stenting (must bill one of these primary codes to meet coverage under 20.7B2, 20.7B3, 20.7B4)*

I63.031	*Cerebral infarction due to thrombosis of right carotid artery*
I63.032	*Cerebral infarction due to thrombosis of left carotid artery*
I63.033	*Cerebral infarction due to thrombosis of bilateral carotid arteries*
I63.131	*Cerebral infarction due to embolism of right carotid artery*
I63.132	*Cerebral infarction due to embolism of left carotid artery*
I63.133	*Cerebral infarction due to embolism of bilateral carotid arteries*
I63.231	*Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries*
I63.232	*Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries*
I63.233	*Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries*
I65.21	*Occlusion and stenosis of right carotid artery*
I65.22	*Occlusion and stenosis of left carotid artery*
I65.23	*Occlusion and stenosis of bilateral carotid arteries*

ICD-10-PCS codes may be used.

037G34Z	*Dilation of Intracranial Artery with Drug-eluting Intraluminal Device, Percutaneous Approach*
037G35Z	*Dilation of Intracranial Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach*
037G36Z	*Dilation of Intracranial Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach*
037G37Z	*Dilation of Intracranial Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach*
037G3DZ	*Dilation of Intracranial Artery with Intraluminal Device, Percutaneous Approach*
037G3EZ	*Dilation of Intracranial Artery with Two Intraluminal Devices, Percutaneous Approach*
037G3FZ	*Dilation of Intracranial Artery with Three Intraluminal Devices, Percutaneous Approach*
037G3GZ	*Dilation of Intracranial Artery with Four or More Intraluminal Devices, Percutaneous Approach*
037G44Z	*Dilation of Intracranial Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach*
037G45Z	*Dilation of Intracranial Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach*
037G46Z	*Dilation of Intracranial Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach*
037G47Z	*Dilation of Intracranial Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach*
037G4DZ	*Dilation of Intracranial Artery with Intraluminal Device, Percutaneous Endoscopic Approach*
037G4EZ	*Dilation of Intracranial Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach*
037G4FZ	*Dilation of Intracranial Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach*
037G4GZ	*Dilation of Intracranial Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach*

037H34Z	Dilation of Right Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037H35Z	Dilation of Right Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037H36Z	Dilation of Right Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037H37Z	Dilation of Right Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037H3DZ	Dilation of Right Common Carotid Artery with Intraluminal Device, Percutaneous Approach
037H3EZ	Dilation of Right Common Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037H3FZ	Dilation of Right Common Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037H3GZ	Dilation of Right Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037H44Z	Dilation of Right Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037H45Z	Dilation of Right Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037H46Z	Dilation of Right Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037H47Z	Dilation of Right Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037H4DZ	Dilation of Right Common Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037H4EZ	Dilation of Right Common Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037H4FZ	Dilation of Right Common Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037H4GZ	Dilation of Right Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037J34Z	Dilation of Left Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037J35Z	Dilation of Left Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037J36Z	Dilation of Left Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037J37Z	Dilation of Left Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037J3DZ	Dilation of Left Common Carotid Artery with Intraluminal Device, Percutaneous Approach
037J3EZ	Dilation of Left Common Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037J3FZ	Dilation of Left Common Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037J3GZ	Dilation of Left Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037J44Z	Dilation of Left Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037J45Z	Dilation of Left Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037J46Z	Dilation of Left Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037J47Z	Dilation of Left Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037J4DZ	Dilation of Left Common Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037J4EZ	Dilation of Left Common Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach

037J4FZ	Dilation of Left Common Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037J4GZ	Dilation of Left Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037K34Z	Dilation of Right Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037K35Z	Dilation of Right Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037K36Z	Dilation of Right Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037K37Z	Dilation of Right Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037K3DZ	Dilation of Right Internal Carotid Artery with Intraluminal Device, Percutaneous Approach
037K3EZ	Dilation of Right Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037K3FZ	Dilation of Right Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037K3GZ	Dilation of Right Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037K44Z	Dilation of Right Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037K45Z	Dilation of Right Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037K46Z	Dilation of Right Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037K47Z	Dilation of Right Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037K4DZ	Dilation of Right Internal Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037K4EZ	Dilation of Right Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037K4FZ	Dilation of Right Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037K4GZ	Dilation of Right Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037L34Z	Dilation of Left Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037L35Z	Dilation of Left Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037L36Z	Dilation of Left Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037L37Z	Dilation of Left Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037L3DZ	Dilation of Left Internal Carotid Artery with Intraluminal Device, Percutaneous Approach
037L3EZ	Dilation of Left Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037L3FZ	Dilation of Left Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037L3GZ	Dilation of Left Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037L44Z	Dilation of Left Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037L45Z	Dilation of Left Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037L46Z	Dilation of Left Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037L47Z	Dilation of Left Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach

037L4DZ	Dilation of Left Internal Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037L4EZ	Dilation of Left Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037L4FZ	Dilation of Left Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037L4GZ	Dilation of Left Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037M34Z	Dilation of Right External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037M35Z	Dilation of Right External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037M36Z	Dilation of Right External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037M37Z	Dilation of Right External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037M3DZ	Dilation of Right External Carotid Artery with Intraluminal Device, Percutaneous Approach
037M3EZ	Dilation of Right External Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037M3FZ	Dilation of Right External Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037M3GZ	Dilation of Right External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037M44Z	Dilation of Right External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037M45Z	Dilation of Right External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037M46Z	Dilation of Right External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037M47Z	Dilation of Right External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037M4DZ	Dilation of Right External Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037M4EZ	Dilation of Right External Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037M4FZ	Dilation of Right External Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037M4GZ	Dilation of Right External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037N34Z	Dilation of Left External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037N35Z	Dilation of Left External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037N36Z	Dilation of Left External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037N37Z	Dilation of Left External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037N3DZ	Dilation of Left External Carotid Artery with Intraluminal Device, Percutaneous Approach
037N3EZ	Dilation of Left External Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037N3FZ	Dilation of Left External Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037N3GZ	Dilation of Left External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037N44Z	Dilation of Left External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037N45Z	Dilation of Left External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach

037N46Z	*Dilation of Left External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach*
037N47Z	*Dilation of Left External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach*
037N4DZ	*Dilation of Left External Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach*
037N4EZ	*Dilation of Left External Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach*
037N4FZ	*Dilation of Left External Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach*
037N4GZ	*Dilation of Left External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach*

160.4 – 510k Post-Approval Extension Studies using 510k-Cleared Embolic Protection Devices during Carotid Artery Stenting (CAS) Procedures

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

A. Background

As explained above in section 160.2, the Centers for Medicare & Medicaid Services (CMS) issued instructions in 2004 for processing claims for carotid artery stenting (CAS) procedures performed in Food and Drug Administration (FDA)-approved post-approval studies. As the post-approval studies began to end, CMS received requests to extend coverage for the post-approval studies. As explained above in section 160.2.1, CMS reviewed the extension requests and determined that patients participating in post-approval extension studies were also included in the covered population of patients participating in FDA-approved post-approval studies.

Recently, the FDA issued 510k approvals for proximal embolic protection devices (EPDs) which are utilized in CAS procedures. Utilization of an EPD is required in the Percutaneous Transluminal Angioplasty (PTA) national coverage determination (NCD) at Pub. 100-03, chapter 1, section 20.7. However the 510k process does not involve a post- approval study requirement as traditional FDA marketing approvals require. CMS received requests to include patients participating in studies following the FDA 510k approval of these devices under NCD 20.7. CMS subsequently determined that these patients, similar to patients covered in traditional post-approval extension studies, are eligible for coverage under the current coverage policy at NCD 20.7.

The FDA does not require devices approved through the 510k process to undergo further study following clearance. As such, 510k post-approval extension studies are neither required by the FDA or subject to FDA approval. However, for the purposes of study review, the FDA evaluates traditional post-approval extension studies and 510k post- approval extension studies via the Pre-Investigational Device Exemption (IDE) process. As a result of the Pre-IDE process, each study is assigned and identified by a single, 6-digit pre-IDE number, preceded by the letter ‘I’ (i.e. I123456).

B.Policy

Effective October 22, 2010, CMS has determined that all 510k post-approval extension studies must be reviewed by the FDA. The FDA will issue an acknowledgement letter stating that the extension study is scientifically valid and will generate clinically relevant post-market data. Upon receipt of this letter and review of the 510k post-approval extension study protocol, CMS will issue a letter to the study sponsor indicating that the study under review will be covered by Medicare. Since the FDA evaluates these studies via the Pre-IDE process, each 510k post-approval extension study will be identified by the ‘I’ number assigned to the study when submitted to the FDA for review (i.e., the FREEDOM study

examining the 510k-cleared Gore Flow Reversal System was assigned I090962 and will be identified as such on all claims).

C. Billing

In order to receive Medicare coverage for patients participating in 510k post-approval extension studies, providers shall follow the same processes as explained above in section 160.2.1 (CAS for Post-Approval Studies). The only difference is that providers must report 510k-cleared devices with a pre-IDE number beginning with an "I", instead of an IDE number beginning with a "P" (post-market approval).

Contractors will issue a letter assigning an effective date for each facility's participation in the extension study. Providers may bill for procedures performed in the extension study for dates of service on and after the assigned effective date utilizing the most current ICD-*10* CM procedure codes.

161 - Intracranial Percutaneous Transluminal Angioplasty (PTA) With Stenting

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

A. Background

In the past, PTA to treat obstructive lesions of the cerebral arteries was non-covered by Medicare because the safety and efficacy of the procedure had not been established. This national coverage determination (NCD) meant that the procedure was also non-covered for beneficiaries participating in Food and Drug Administration (FDA)-approved investigational device exemption (IDE) clinical trials.

B. Policy

On February 9, 2006, a request for reconsideration of this NCD initiated a national coverage analysis. CMS reviewed the evidence and determined that intracranial PTA with stenting is reasonable and necessary under §1862(a)(1)(A) of the Social Security Act for the treatment of cerebral vessels (as specified in The National Coverage Determinations Manual, Chapter 1, part 1, section 20.7) only when furnished in accordance with FDA- approved protocols governing Category B IDE clinical trials. All other indications for intracranial PTA with stenting remain non-covered.

- **Billing**

Providers of covered intracranial PTA with stenting shall use Category B IDE billing requirements, as listed above in section 68.4. In addition to these requirements, providers must bill the appropriate procedure and diagnosis codes for the date of service to receive payment.

See the below ICD-10-CM diagnosis codes list applies, depending on the date of service. Indications for PTA and Stenting of Intracranial Arteries (must bill I67.2 and one of these primary codes to meet coverage under 20.7B5)

If ICD-10-CM is applicable:

I67.2 Cerebral atherosclerosis
I66.01 Occlusion and stenosis of right middle cerebral artery
I66.02 Occlusion and stenosis of left middle cerebral artery
I66.03 Occlusion and stenosis of bilateral middle cerebral arteries
I66.11 Occlusion and stenosis of right anterior cerebral artery
I66.12 Occlusion and stenosis of left anterior cerebral artery
I66.13 Occlusion and stenosis of bilateral anterior cerebral arteries
I66.21 Occlusion and stenosis of right posterior cerebral artery

I66.22 Occlusion and stenosis of left posterior cerebral artery
I66.23 Occlusion and stenosis of bilateral posterior cerebral arteries
I66.8 Occlusion and stenosis of other cerebral arteries
I63.59 Cerebral infarction due to unspecified occlusion or stenosis of other cerebral artery

If ICD-10-PCS is applicable, ICD-10-PCS procedure codes.
That is, under Part A, providers must bill intracranial PTA using if ICD-10-PCS procedure codes is applicable.

037G34Z	Dilation of Intracranial Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037G35Z	Dilation of Intracranial Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037G36Z	Dilation of Intracranial Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037G37Z	Dilation of Intracranial Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037G3DZ	Dilation of Intracranial Artery with Intraluminal Device, Percutaneous Approach
037G3EZ	Dilation of Intracranial Artery with Two Intraluminal Devices, Percutaneous Approach
037G3FZ	Dilation of Intracranial Artery with Three Intraluminal Devices, Percutaneous Approach
037G3GZ	Dilation of Intracranial Artery with Four or More Intraluminal Devices, Percutaneous Approach
037G44Z	Dilation of Intracranial Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037G45Z	Dilation of Intracranial Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037G46Z	Dilation of Intracranial Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037G47Z	Dilation of Intracranial Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037G4DZ	Dilation of Intracranial Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037G4EZ	Dilation of Intracranial Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037G4FZ	Dilation of Intracranial Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037G4GZ	Dilation of Intracranial Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037H34Z	Dilation of Right Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037H35Z	Dilation of Right Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037H36Z	Dilation of Right Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037H37Z	Dilation of Right Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037H3DZ	Dilation of Right Common Carotid Artery with Intraluminal Device, Percutaneous Approach
037H3EZ	Dilation of Right Common Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037H3FZ	Dilation of Right Common Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037H3GZ	Dilation of Right Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037H44Z	Dilation of Right Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037H45Z	Dilation of Right Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach

037H46Z	Dilation of Right Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037H47Z	Dilation of Right Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037H4DZ	Dilation of Right Common Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037H4EZ	Dilation of Right Common Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037H4FZ	Dilation of Right Common Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037H4GZ	Dilation of Right Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037J34Z	Dilation of Left Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037J35Z	Dilation of Left Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037J36Z	Dilation of Left Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037J37Z	Dilation of Left Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037J3DZ	Dilation of Left Common Carotid Artery with Intraluminal Device, Percutaneous Approach
037J3EZ	Dilation of Left Common Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037J3FZ	Dilation of Left Common Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037J3GZ	Dilation of Left Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037J44Z	Dilation of Left Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037J45Z	Dilation of Left Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037J46Z	Dilation of Left Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037J47Z	Dilation of Left Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037J4DZ	Dilation of Left Common Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037J4EZ	Dilation of Left Common Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037J4FZ	Dilation of Left Common Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037J4GZ	Dilation of Left Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037K34Z	Dilation of Right Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037K35Z	Dilation of Right Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037K36Z	Dilation of Right Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037K37Z	Dilation of Right Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037K3DZ	Dilation of Right Internal Carotid Artery with Intraluminal Device, Percutaneous Approach
037K3EZ	Dilation of Right Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037K3FZ	Dilation of Right Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037K3GZ	Dilation of Right Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach

037K44Z	Dilation of Right Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037K45Z	Dilation of Right Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037K46Z	Dilation of Right Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037K47Z	Dilation of Right Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037K4DZ	Dilation of Right Internal Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037K4EZ	Dilation of Right Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037K4FZ	Dilation of Right Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037K4GZ	Dilation of Right Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037L34Z	Dilation of Left Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037L35Z	Dilation of Left Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037L36Z	Dilation of Left Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037L37Z	Dilation of Left Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037L3DZ	Dilation of Left Internal Carotid Artery with Intraluminal Device, Percutaneous Approach
037L3EZ	Dilation of Left Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037L3FZ	Dilation of Left Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037L3GZ	Dilation of Left Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037L44Z	Dilation of Left Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037L45Z	Dilation of Left Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037L46Z	Dilation of Left Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037L47Z	Dilation of Left Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037L4DZ	Dilation of Left Internal Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037L4EZ	Dilation of Left Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037L4FZ	Dilation of Left Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037L4GZ	Dilation of Left Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037M34Z	Dilation of Right External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037M35Z	Dilation of Right External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037M36Z	Dilation of Right External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037M37Z	Dilation of Right External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037M3DZ	Dilation of Right External Carotid Artery with Intraluminal Device, Percutaneous Approach

037M3EZ	Dilation of Right External Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037M3FZ	Dilation of Right External Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037M3GZ	Dilation of Right External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037M44Z	Dilation of Right External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037M45Z	Dilation of Right External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037M46Z	Dilation of Right External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037M47Z	Dilation of Right External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037M4DZ	Dilation of Right External Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037M4EZ	Dilation of Right External Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037M4FZ	Dilation of Right External Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037M4GZ	Dilation of Right External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
037N34Z	Dilation of Left External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037N35Z	Dilation of Left External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
037N36Z	Dilation of Left External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
037N37Z	Dilation of Left External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
037N3DZ	Dilation of Left External Carotid Artery with Intraluminal Device, Percutaneous Approach
037N3EZ	Dilation of Left External Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
037N3FZ	Dilation of Left External Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
037N3GZ	Dilation of Left External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
037N44Z	Dilation of Left External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037N45Z	Dilation of Left External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037N46Z	Dilation of Left External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037N47Z	Dilation of Left External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
037N4DZ	Dilation of Left External Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037N4EZ	Dilation of Left External Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
037N4FZ	Dilation of Left External Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
037N4GZ	Dilation of Left External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach

Under Part B, providers must bill HCPCS procedure code 37799. If above ICD-10-CM is applicable.

NOTE: ICD- codes are subject to modification. Providers must always ensure they are using the latest and most appropriate codes.

250.2– Billing Requirements

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Institutional clinical trial claims for pharmacogenomic testing for warfarin response are identified through the presence of all of the following elements:

- Value Code D4 and 8-digit clinical trial number (when present on the claim) - Refer to Transmittal 310, Change Request 5790, dated January 18, 2008;
- ICD-10 diagnosis code *Z00.6 (secondary)* - Refer to Transmittal 310, Change Request 5790, dated January 18, 2008; *and Z79.01 (primary);*
- Condition Code 30 - Refer to Transmittal 310, Change Request 5790, dated January 18, 2008;
- HCPCS modifier Q0: outpatient claims only - Refer to Transmittal 1418, Change Request 5805, dated January 18, 2008; and,
- HCPCS code G9143 (mandatory with the April 2010 Integrated Outpatient Code Editor (IOCE) and the January 2011 Clinical Laboratory Fee Schedule (CLFS) updates. Prior to these times, any trials should bill FIs for this test as they currently do absent these instructions, and the FIs should process and pay those claims accordingly.)

Practitioner clinical trial claims for pharmacogenomic testing for warfarin response are identified through the presence of all of the following elements:

- ICD-*10*-diagnosis code *Z00.6 (secondary), and ICD-10 diagnosis code Z79.01 (primary) MCS edit 031L70.7;*
- 8-digit clinical trial number(when present on the claim);
- HCPCS modifier Q0; and, *MCS edit 031L*
- HCPCS code G9143 (to be carrier priced for claims with dates of service on and after August 3, 2009, that are processed prior to the January 2011 CLFS update.)

NOTE: This NCD does not determine coverage to identify CYP2C9 or VKORC1 alleles for other purposes beside warfarin responsiveness, nor does it determine national coverage to identify other alleles to predict warfarin responsiveness. These decisions are made at the local MAC level.

250.3 – Payment Requirements

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Beginning April 5, 2010, for claims with dates of service on and after August 3, 2009, the Medicare Shared System will track the number of times a beneficiary receives pharmacogenomic testing for warfarin response. When a claim is received for pharmacogenomic testing for warfarin response, and the shared system has determined that the beneficiary has already received the test in his/her lifetime, it will

generate a Medicare line-item denial and the Medicare contractor will provide the following messages to enforce the one-time limitation for the test:

Claim Adjustment Reason Code (CARC) 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. This change to be effective April 1, 2010: These are non-covered services because this is not deemed a 'medical necessity' by the payer.

NOTE: Refer to the 835 Healthcare Policy Identification Segment, if present.

Remittance Advice Remark Code (RARC) N362 – The number of Days or Units of Service exceeds our acceptable maximum.

Group Code CO – Contractual Obligation

Medicare Summary Notice (MSN) 16.76 – This service/item was not covered because you have exceeded the lifetime limit for getting this service/item. (Este servicio/artículo no fue cubierto porque usted ya se ha pasado del límite permitido de por vida, para recibirlo.).

The Medicare shared system and the A/B MACs (B) will also ensure that pharmacogenomic testing for warfarin response is billed in accordance with clinical trial reporting requirements. In other words, the shared system and the A/B MACs (B) will return to provider/return as unprocessable lines for pharmacogenomic testing for warfarin response when said line is not billed with *HCPCS modifier Q0 and ICD-10- CM diagnosis code if applicable, ICD-10-CM Z00.6 is not present as a secondary diagnosis*. When the system or the A/B MAC (B) initiates the line- item return to provider or returns the claim as unprocessable, the Medicare contractor will respond with the following messages:

For a missing Q0 modifier:
CARC 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.

For a missing Z00.6 diagnosis code when a HCPCS Q0 modifier is reported with HCPCS G9143:

CARC 16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Remark Code M64 - Missing/incomplete/invalid other diagnosis.

For either a missing Q0 modifier and/or a missing ICD-10-CM Z00.6 diagnosis code:

Group Code CO- Contractual Obligation

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

260.1.1– Hospital Billing Instructions

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

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*

The applicable NCD is 250.5 Facial Lipodystrophy.

B - Outpatient Prospective Payment System (OPPS) Hospitals or Ambulatory Surgical Centers (ASCs):

For line item dates of service on or after March 23, 2010, and until HCPCS codes Q2026 and Q2027 are billable, facial LDS claims shall contain a temporary HCPCS code C9800, instead of HCPCS G0429 and HCPCS Q2026/Q2027, as shown above.

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

C - Hospital Inpatient Claims

Hospitals must bill covered dermal injections for treatment of facial LDS by having all of the required elements on the claim:

B. Discharge date on or after March 23, 2010,

C. If ICD-10-PCS is applicable,

- *ICD-10-PCS procedure code 3E00XGC Introduction of Other Therapeutic Substance into Skin and Mucous Membrances, External Approach, or*

D. If ICD-10-CM is applicable on or after 10/01/2015,

- *ICD-10-CM diagnosis codes B20 Human Immunodeficiency Virus [HIV] disease and E88.1 Lipodystrophy not elsewhere classified.*

A diagnosis code for a comorbidity of depression may also be required for coverage on an outpatient and/or inpatient basis as determined by the individual Medicare contractor's policy.

260.2.2– Practitioner Billing Instructions

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Practitioners must bill covered claims for dermal injections for treatment of facial LDS by having all of the required elements on the claim:

Performed in a non-facility setting:

- A line with HCPCS codes Q2026 or Q2027 with a LIDOS on or after March 23, 2010,

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

- A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010,

51 If ICD-10-CM applies, diagnosis codes B20 Human Immunodeficiency Virus (HIV) disease and E88.1 (Lipodystrophy not elsewhere classified). Both diagnoses are required on the claim.

NOTE: A diagnosis code for a comorbidity of depression may also be required for coverage based on the individual Medicare contractor's policy.

52 A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010,

53 If ICD-10 CM- applies, ICD-10-CM diagnosis codes B20 Human immunodeficiency Virus (HIV) disease and E88.1 (Lipodystrophy not elsewhere classified). Both diagnoses are required on the claim.

NOTE: A diagnosis code for a comorbidity of depression may also be required for coverage based on the individual Medicare contractor's policy.

• 260.3 Claims Processing System Editing

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Billing for Services Prior to Medicare Coverage

Hospitals and practitioners billing for dermal injections for treatment of facial LDS prior to the coverage date of March 23, 2010, will receive the following messages upon their Medicare denial:

- *Claim Adjustment Reason Code (CARC) 26: Expenses incurred prior to coverage.*

NOTE: Outpatient hospitals and beneficiaries that received services in a hospital outpatient setting may receive different message as established by their particular Medicare contractor processing the claim.)

Medicare beneficiaries whose provider bills Medicare for dermal injections for treatment of facial LDS prior to the coverage date of March 23, 2010, will receive the following Medicare Summary Notice (MSN) message upon the Medicare denial:

- - This service was not covered by Medicare at the time you received it. (Spanish Version: Este servicio no estaba cubierto por Medicare cuando usted lo recibió.)

Billing for Services Not Meeting Comorbidity Coverage Requirements

Hospitals and practitioners billing for dermal injections for treatment of facial LDS on patients that do not have a comorbidity of HIV and lipodystrophy (or even depression if deemed required by the Medicare contractor) will receive the following messages upon their Medicare denial:

- CARC 50: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- RARC N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of

this policy is available at http://www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

- RARC M64: Missing/incomplete/invalid other diagnosis.
- Group Code: CO

Medicare beneficiaries who do not meet Medicare comorbidity requirements of HIV and lipodystrophy (or even depression if deemed required by the Medicare contractor) and whose provider bills Medicare for dermal injections for treatment of facial LDS will receive the following MSN message upon the Medicare denial:

15.4 - The information provided does not support the need for this service or item. (Spanish Version: La información proporcionada no confirma la necesidad para este servicio oículo.)

300.2 Claims Processing Requirements for OPT with Verteporfin Services on Professional Claims and Outpatient Facility Claims

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

OPT with Verteporfin is a covered service when billed with the below ICD-*10*-CM codes

Nationally Covered ICD-10-CM codes

H35.3210	*Exudative age-related macular degeneration, right eye, stage unspecified*
H35.3211	*Exudative age-related macular degeneration, right eye, with active choroidal neovascularization*
H35.3212	*Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization*
H35.3213	*Exudative age-related macular degeneration, right eye, with inactive scar*
H35.3220	*Exudative age-related macular degeneration, left eye, stage unspecified*
H35.3221	*Exudative age-related macular degeneration, left eye, with active choroidal neovascularization*
H35.3222	*Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization*
H35.3223	*Exudative age-related macular degeneration, left eye, with inactive scar*
H35.3230	*Exudative age-related macular degeneration, bilateral, stage unspecified*
H35.3231	*Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization*
H35.3232	*Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization*
H35.3233	*Exudative age-related macular degeneration, bilateral, with inactive scar*

ICD-10- Codes for OPT with Verteporfin for other ocular indications are eligible for local coverage determinations through individual contractor discretion.

B39.4	*Histocapsulati, unspecified*
	(Translates to combination of both B39.4 & H32)

B39.5	*Histoplasmosis duboisii*
	(Requires H32 coverage)
B39.9	*Histoplasmosis, unspecified*
	(Requires H32 coverage)
H32	*Chorioretinal disorders in diseases classified elsewhere*
	(Requires B39.4 coverage)
H44.2A1	*Degenerative myopia with choroidal neovascularization, right eye*
H44.2A2	*Degenerative myopia with choroidal neovascularization, left eye*
H44.2A3	*Degenerative myopia with choroidal neovascularization, bilateral eye*
H44.2B1	*Degenerative myopia with macular hole, right eye*
H44.2B2	*Degenerative myopia with macular hole, left eye*
H44.2B3	*Degenerative myopia with macular hole, bilateral eye*
H44.2C1	*Degenerative myopia with retinal detachment, right eye*
H44.2C2	*Degenerative myopia with retinal detachment, left eye*
H44.2C3	*Degenerative myopia with retinal detachment, bilateral eye*
H44.2D1	*Degenerative myopia with foveoschisis, right eye*
H44.2D2	*Degenerative myopia with foveoschisis, left eye*
H44.2D3	*Degenerative myopia with foveoschisis, bilateral eye*
H44.2E1	*Degenerative myopia with other maculopathy, right eye*
H44.2E2	*Degenerative myopia with other maculopathy, left eye*
H44.2E3	*Degenerative myopia with other maculopathy, bilateral eye*
H44.21	*Degenerative Myopia, right eye*
H44.22	*Degenerative Myopia, left eye*
H44.23	*Degenerative Myopia, bilateral*
H35.711	*Central serous chorioretinopathy, right eye*
H35.712	*Central serous chorioretinopathy, left eye*
H35.713	*Central serous chorioretinopathy, bilateral*

Coverage is denied when billed with the below Nationally Non-Covered ICD-10-CM codes

Nationally Non-Covered ICD-10-CM codes:

H35.30	*Unspecified macular degeneration*
H35.3110	*Nonexudative age-related macular degeneration, right eye, stage unspecified*
H35.3111	*Nonexudative age-related macular degeneration, right eye, early dry stage*
H35.3112	*Nonexudative age-related macular degeneration, right eye, intermediate dry stage*
H35.3113	*Nonexudative age-related macular degeneration, right eye, advanced atrophic without subfoveal involvement*
H35.3114	*Nonexudative age-related macular degeneration, right eye, advanced atrophic with subfoveal involvement*
H35.3120	*Nonexudative age-related macular degeneration, left eye, stage unspecified*
H35.3121	*Nonexudative age-related macular degeneration, left eye, early dry stage*
H35.3122	*Nonexudative age-related macular degeneration, left eye, intermediate dry stage*
H35.3123	*Nonexudative age-related macular degeneration, left eye, advanced atrophic without subfoveal involvement*
H35.3124	*Nonexudative age-related macular degeneration, left eye, advanced atrophic with subfoveal involvement*
H35.3130	*Nonexudative age-related macular degeneration, bilateral, stage unspecified*
H35.3131	*Nonexudative age-related macular degeneration, bilateral, early dry stage*
H35.3132	*Nonexudative age-related macular degeneration, bilateral, intermediate dry stage*

H35.3133	*Nonexudative age-related macular degeneration, bilateral, advanced atrophic without subfoveal involvement*
H35.3134	*Nonexudative age-related macular degeneration, bilateral, advanced atrophic with subfoveal involvement*

Payment for OPT service (CPT code 67221/67225) must be billed on the same claim as the drug (J3396) for the same date of service.

Claims for OPT with Verteporfin for dates of service prior to April 3, 2013 are covered at the initial visit as determined by a fluorescein angiogram (FA) CPT code 92235 .
Subsequent follow-up visits also require a FA prior to treatment.

For claims with dates of service on or after April 3, 2013, contractors shall accept and process claims for subsequent follow-up visits with either a FA, CPT code 92235, or optical coherence tomography (OCT), CPT codes 92133 or 92134, prior to treatment.

Regardless of the date of service of the claim, the FA or OCT is not required to be submitted on the claim for OPT and can be maintained in the patient's file for audit purposes.

300.3- Claims Processing Requirements for OPT with Verteporfin Services on Inpatient Facility Claims

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Inpatient facilities shall report *ICD-10-CM codes H35.3210-H35.3233 (Exudative Age-related Macular Degeneration) and ICD-10-PCS codes 085E3ZZ (Destruction of Right Retina, Percutaneous Approach) and 085F3ZZ (Destruction of Left Retina, Percutaneous Approach)*

370.1 - Coding and Claims Processing for MTWA

(Rev.11161; Issued: 12-14-21; Effective:10-29-21; Implementation: 10-29-21)

Effective for claims with dates of service on and after March 21, 2006, MACs shall accept CPT 93025 (MTWA for assessment of ventricular arrhythmias) for MTWA diagnostic testing for the evaluation of patients at risk for SCD with the SA method of analysis only. All other methods of analysis for MTWA are non-covered.

Effective for claims with dates of service on and after January 13, 2015, MACs shall at their discretion determine coverage for CPT 93025 for MTWA diagnostic testing for the evaluation of patients at risk for SCD with methods of analysis other than SA. The –KX modifier shall be used as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the MTWA was performed using a method of analysis other than SA for the evaluation of patients at risk for SCD from ventricular arrhythmias and that all other NCD criteria was met.

NOTE: The –KX modifier is NOT required on MTWA claims for the evaluation of patients at risk for SCD if the SA analysis method is used.

NOTE: This diagnosis code list/translation was approved by CMS/Coverage. It may or may not be a complete list of covered indications/diagnosis codes that are covered but should serve as a finite starting point.

As this policy indicates, individual A/B MACs within their respective jurisdictions have the discretion to make coverage determinations they deem reasonable and necessary under section 1862(a)1)(A) of the Social Security Act. Therefore, A/B MACs may have additional covered diagnosis codes in their individual policies where contractor discretion is appropriate.

ICD-10-Codes:

ICD-10 CM	***ICD-10 DX Description***
I21.01	*ST elevation (STEMI) myocardial infarction involving left main coronary artery*
I21.02	*ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery*
I21.09	*ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall*
I21.11	*ST elevation (STEMI) myocardial infarction involving right coronary artery*
I21.19	*ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall*
I21.21	*ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery*
I21.29	*ST elevation (STEMI) myocardial infarction involving other sites*
I21.3	*ST elevation (STEMI) myocardial infarction of unspecified site*
I21.4	*Non-ST elevation (NSTEMI) myocardial infarction*
I21.A1	*Myocardial infarction type 2*
I22.0	*Subsequent ST elevation (STEMI) myocardial infarction of anterior wall*
I22.1	*Subsequent ST elevation (STEMI) myocardial infarction of inferior wall*
I22.2	*Subsequent non-ST elevation (NSTEMI) myocardial infarction*
I22.8	*Subsequent ST elevation (STEMI) myocardial infarction of other sites*
I22.9	*Subsequent ST elevation (STEMI) myocardial infarction of unspecified site*
I24.8	*Other forms of acute ischemic heart disease*
I24.9	*Acute ischemic heart disease, unspecified*
I47.0	*Re-entry ventricular arrhythmia*
I47.2	*Ventricular tachycardia*
I49.01	*Ventricular fibrillation*
I49.02	*Ventricular flutter*
R55	*Syncope and collapse*