CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11388	<b>Date: April 29, 2022</b>
	Change Request 12691

SUBJECT: National Coverage Determination (NCD) 210.14 Reconsideration – Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

**I. SUMMARY OF CHANGES:** The purpose of this change request is to inform interested parties that effective February 10, 2022, CMS is expanding beneficiary eligibility for screening for lung cancer with LDCT.

## **EFFECTIVE DATE: February 10, 2022**

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

**IMPLEMENTATION DATE: October 3, 2022** 

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated) R=REVISED, N=NEW, D=DELETED-*Only One Per Row*.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/220/4/Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
R	18/220/5/Common Working File (CWF) Edits

#### 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:11388	<b>Date: April 29, 2022</b>	Change Request: 12691
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**SUBJECT:** National Coverage Determination (NCD) 210.14 Reconsideration – Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

**EFFECTIVE DATE: February 10, 2022** 

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

**IMPLEMENTATION DATE: October 3, 2022** 

#### I. GENERAL INFORMATION

- **A. Background:** Lung cancer is the third most common cancer and the leading cause of cancer deaths in the United States. Cancer of the lung and bronchus accounted for over 130,000 deaths in 2021 (more than the total number of estimated deaths from colon, breast and prostate cancer combined) with a median age at death of 72 years. Screening is aimed at early detection of non-small cell lung cancer. The only recommended screening test for lung cancer is LDCT. It is a unique Computerized Tomography (CT) scan technique that combines special x-ray equipment with sophisticated computers to produce multiple, cross-sectional images or pictures of the inside of the body.
- **B.** Policy: Effective February 10, 2022, CMS is expanding beneficiary eligibility for screening for lung cancer with LDCT to closely align with the United States Preventive Services Task Force's recommendation. CMS is lowering the minimum age for screening from 55 to 50 years and reducing the smoking history from at least 30 pack-years to at least 20 pack-years. The policy simplifies requirements for the counseling and shared decision-making visit, removes the restriction that it must be furnished by a physician or non-physician practitioner, reduces the eligibility criteria for the reading radiologist, and reduces the radiology imaging facility eligibility criteria (including removes the requirement that facilities participate in a registry).

Additional information: For original implementing instructions and the most recent coding updates please refer to the following links:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r10832otn

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2015-Transmittals-Items/R3374CP

Note: As a result of the revised eligibility criteria for this NCD, CMS is replacing the current text of Section 210.14 of the NCD Manual (Pub 100-03), Chapter 1, Part 4, and section 220, Chapter 18 of the Claims Processing Manual, Pub 100-4.

# II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC		A/B MAC   DME   Shared-System Maintainer				tainers	Other	
		A	В	ННН		FISS	MCS	VMS	CWF	
					MAC					
12691 -	Effective for claims with dates	X	X							
04.1	of service on and after February									
	10, 2022, contractors shall									

Number	Requirement	Re	spoi	nsibility	,					
		A	/B I	MAC	DME	Share	d-Syste	m Main	tainers	Other
		A	В	ННН	MAC	FISS	MCS	VMS	CWF	
	continue to pay claims for lung cancer screening with LDCT based on the revised eligibility criteria as described in Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Section 210.14, and Pub 100-04 Medicare Claims Processing Manual, Chapter 18, Sections 220.4 and 220.5.				MAC					
12691 - 04.2	Contractors shall revise their edit to allow codes G0296 and 71271 to be billed only if the beneficiary is between the ages of 50 and 77 for claims with date of service on or after February 10, 2022.					X			X	
12691 - 04.3	Contractors shall not search for LDCT claims with dates of service February 10, 2022 to October 3, 2022, but may adjust claims that are brought to their attention.	X	X							

# III. PROVIDER EDUCATION TABLE

Number	Requirement	Re	spoi	nsibility	,	
			A/ M/		DME MAC	CEDI
		A	В	ННН		
12691 - 04.4	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listsery to get	X	X			

Number	Requirement	Responsibility				
			A/ M/		DME MAC	CEDI
		A	В	ННН		
	MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.					

#### IV. SUPPORTING INFORMATION

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

<sup>&</sup>quot;Should" denotes a recommendation.

X-Ref	Recommendations or other supporting information:
Requirement	
Number	

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

#### V. CONTACTS

Pre-Implementation Contact(s): Lisa Davis, lisa.davis@cms.hhs.gov (Coverage and Analysis), Wanda Belle, wanda.belle@cms.hhs.gov (Coverage and Analysis), Wendy Knarr, wendy.knarr@cms.hhs.gov (Supplier Claims), William Ruiz, william.ruiz@cms.hhs.gov (Institutional Claims), Patricia Brocato-Simons, Patricia.brocatosimmons@cms.hhs.gov (Coverage and Analysis), Thomas Dorsey, thomas.dorsey@cms.hhs.gov (Practitioner Claims), Kimberly Long, kimberly.long@cms.hhs.gov (Coverage and Analysis)

**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: 1**

# **Medicare Claims Processing Manual Chapter 18 - Preventive and Screening Services**

Table of Contents (Rev.11388, Issued:04-29, 22)

220.4 – Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages (Rev11388, Issued:04-29, 22; (Effective:02-10-22; Implementation:10-03-22)

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 LDCT lung cancer screening services, HCPCS codes G0296 and 71271:

• Denying services submitted on a TOB other than 12X, 13X, 22X, 23X, 71X, 77X, 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 and MSN 8.81.

**NOTE**: Effective December 31, 2020, HCPCS code G0297 is end-dated and replaced with 71271.

• Denying services for HCPCS G0296 for TOBs 71X and 77X when G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71X TOBs), for claims with dates of service on and after February 5, 2015:

CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.

NOTE: 77X TOBs will be processed through the Integrated Outpatient Code Editor under the current process.

Group Code CO assigning financial liability to the provider.

• Denying services where a previous HCPCS G0297 (effective January 1, 2021, G0297 is replaced with 71271), is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening), for claims with dates of service on and after February 5, 2015:

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 policy was used when we made this decision: NCD 210.14."

Spanish Version – "Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 210.14."

Contractors processing institutional claims shall use the following MSN message in addition to MSN 15.20:

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 and MSN 8.81.

• Denying claim lines for HCPCS G0296 and 71271 because the beneficiary is not between the ages of 50 and 77 (55 and 77 for DOS prior to February 10, 2022) at the time the service was rendered:

**NOTE**: Effective December 31, 2020 HCPCS code G0297 is end-dated *and replaced with 71271*.

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."

MSN 15.20: "The following policy was used when we made this decision: NCD 210.14.

Spanish Version – "Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 210.14."

Contractors processing institutional claims shall use the following MSN message in addition to MSN 15.20:

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 (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 and MSN 8.81.

• Denying claim lines for HCPCS G0296 and 71271 because the claim line was not billed with ICD-10 codes Z87.891(personal history of tobacco use/personal history of nicotine dependence), 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), or F17.219 (Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders), effective with dates of service on or after October 1, 2015.

**NOTE**: Effective December 31, 2020, HCPCS code G0297 is end-dated *and replaced with 71271*. 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 policy was used when we made this decision: NCD 210.14.

Spanish Version – "Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 210.14."

Contractors processing institutional claims shall use the following MSN message in addition to MSN 15.20:

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 and MSN 8.81.

# 220.5 – Common Working File (CWF) Edits

(Rev.11388, Issued:04-29, 22; (Effective:02-10-22; Implementation:10-03-22)

The common working file (CWF) shall apply the following limitations to lung cancer screening with LDCT:

Allow one HCPCS code 71271 per annum. At least 11 full months must elapse from the date of the last screening. **NOTE:** This edit shall be overridable.

Reject HCPCS codes G0296 and 71271 claims lines for beneficiaries that are not between the ages of 50 and 77 (55 and 77 for DOS prior to February 10, 2022).

NOTE: Effective December 31, 2020, HCPCS code G0297 is end-dated and replaced with 71271.

R11388\_CP1 ICD Diagnosis

NCD:	210.14								
NCD Title:	Screening for Lung Cancer with Low Dose Computed Tomography								
	IOM: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9246.pdf								
MCD:	MCD: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3374CP.pdf								
		ICD-10 CM	ICD-10 DX Description						
		287.891	Personal history of tobacco use/personal history of nicotine dependence						
	F	17.210	Nicotine dependence, cigarettes, uncomplicated						
	F	17.211	Nicotine dependence, cigarettes, in remission						
	F	17.213	Nicotine dependence, cigarettes, with withdrawal						
	F	17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders						
	F	17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders						

R11388\_CP1 ICD Procedures

NCD:	210.14							
NCD Title:	Screening for Lung Cancer with Low Dose Computed Tomography							
IOM:	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9246.pdf							
MCD:	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R337	74CP.pdf						
		ICD-10	ICD-10 PCS Description					
		N/A	N/A					

NCD:	210.14 Screening for Lung Cencer with Low Dose Computed Tomography i	CR9246 CR95	40. CR12124. CR12359. CF	(12691)						
MCD:	https://www.cms.gov/flegulations-and-Guidance/Guidance/Manuats https://www.cms.gov/medicare-coverage-database/view/nof.ascs//n	Downloads/hot odid=354&noty	103c1_Pari4.pd9page=35 er=1&bc=0							
Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency, Age Edits	TOB (Part A)	Revenu e Code Part A	Modifier Part A	Provider Specialty	MSN Mexage Part A	CARC Message Part A	Proposed RARC Message Part A
	AMACE: Effective for line-iterms on claims with DOS 2/5/15, shall recognise and add to systems as appropriate HCPGS 60036- connective visit of docume need for large connex consenting using load dose OT (ECCT) soon (pervisor is for eligibility determation and shared declaims making), and, HCPGS 172/11 - Computed tomography, there, by dose for larg canons consenting, subhoot contest makings, depletion 172/12.	G0295								
Part A	contrast material(s) effective 1/1/21.	71271		12X 13X	NA.	NA.	NA .	NA	NA.	NA
				13X 22X 23X 71X (G0295 only) 77X (G0295						
	FISS/CWF: Shall not apply beneficiary colmunance or deductible to claim lines containings MCPCS G0256 or 71271.NOTE: This includes Part A CPPS and non-CPPS claims.	G0296 71271		only) 85X						
	FISSICWF: Shall create a line-level edit to allow HCPCS 71271 to be billed no more than 1 x per arruran. A least 11 full months must elapse from morth of last acrossing. NOTE: This edit shall be overridable.	71271	1 x per annum		NA.	NA.	NA.	NA.	NA.	NA.
	AMACs: Shall deny line-liams on claims containing HCPCS 71271 when reported more than once in a 12-month period (11 full months must elapse from month of last screening) using the following messages:	71271	1xper annum		NA.	NA.	NA.	15.20	119	N386
	FISSCWF: Shall create an edit to allow HCPCS G0395 & 71271 to be billed only if the baneficiary is between the ages of 55 and 77, (Effective 2/10/22 ages 50-77).	G0296 71271	Age 55-77 2/5/15-2/9/22 Age 50-77 2/10/22-P							
	AMACs: shall deny line-items on claims containing HCPCS G0296 or 71271 when the beneficiary is not between ages 55-77, (Effective 2/10/22 ages 55-77) using the following messages	G0296 71271	Age 55-77 2/5/15-2/9/22 Age 50-77 2/10/22-P		NA.	NA.	NA.	15.20	6	NA.
	FBS: Effective for claims with DOS on and after 2/5/15, shall allow payment for HCPCS G0008 and 71271 only when billed with ICD- 10 287 891, personal history of tobacco uselpersonal history of nicotine dependence OR ICD-10 F17.210, F17.211, F17.213, F17.216, or F17.219, nicotine decemberos, cisarettes.	G0296 71271			NA.	NA.	NA.	NA.	NA.	NA.
Part A	A/MACs: Shall deny line-items on claims containing HCPCS G0256 and 71271 only when not billed with iCD-10 287.891, OR F17.210, F17.211, F17.213, F17.218, or F17.219.	G0296 71271			NA.	NA.	NA.	15.19	167	N386
	AIMACs, FISS: Shall pay for HCPCS codes G0296 and 71271 for the following TOBs on institutional claims as follows:									
	-Hospital outpatient departments (TOBs 12X, 13X) based on COPPS.  Skilled nursing facilities (SNFs) (TOB 22X, 23X) based on Medicane Physician Fee Schedule (MPFS).  -Childa Access Hospitals (CAHs) (TOB 85X) based on reas									
	Cost,  —Rural Health Clinica (191Cs) (TCB 71X) based on  sle-chains rate for C0200 cty).   All controls on the C0200 cty).   TYN based on prospective payment  system rate for C0200 cty).   TYN based on prospective payment  system rate for C0200 cty).   CO-Mit (TCB 50X) Method 5 with RC C020X, C97X, and C90X based  on hazar of adulat charge or the MRYS (115% of the issuer of feat  standard swarps and calculated charges (TSS).   TYN C020X C97X and C90X based  feat  standard swarps of country of C020X C97X.									
	<ul> <li>-CANs (TOB 850) Method II with RC 095X, 097X, and 095X based on lesser of actual charge or the MPFS (115% of the lesser of fee schedule amount and submitted charge) for G0256 only.</li> </ul>	G0296 71271		85X 096X 097X 098X	NA.	NA.	NA.	NA.	NA.	NA.
	AMMACs: shall not pay line-items on claims with G0206 on 71X and 77X T Olds when G0206 is billed on the same day with another visit (his does not supply to PPE for 71X T Olds). The service line with G0206 should be shown as covered with the following ANS0 information:	G0296		85X 096X 097X 098X	NA.	NA.	NA.	16.34	97	NA .
	AMACE: shall deny line-items on institutional claims containing HCIPCS code GDDS when submitted on a TGO other from ETX, TAX, ZZX, ZXX, TYX, TXX, or QIX aurily to Michaely manager.			12X 13X 22X 23X 71X (G0295 only) 77X (G0295 only) 85X						
		G0296		12X 13X 22X 23X 71X (G0296 only) 77X	NA.	NA.	NA .	21.25	170	Nes
	AMACs: shall deny line-items on institutional claims containing HCPCS code 71271 when submitted on a TOB other than 12X, 13X, 22X, 23X, 71X, 77X, or 85X using the following messages:	71271 See lines 7, 21		only) 85X	NA	NA.	NA.	21.25	170	N85
		Proposed HCPCS/CPT						Proposed MSN	Proposed CARC	Proposed RARC
Part 5	Rule Discription Part B.  Elisative for line-laters on criteria will 1005 on or other 25°15.  BBMCs shall inceptive and did to systems one VECPCS 00095- Connecting with of discous more for heary convert recenting to the discous results of the systems on the VECPC 00095- Connecting with of discous more for heary convert recenting to the discous results of the significant point of the other states of the discous results of the significant point of the discous recent point of	Part B	Frequency Limitations	POS (Part 5)	n/a	Modifier Part B	Specialty	Part B	Part 5	8
Part B	CWF: shall create a line-level edit to allow HCPCS 71271 to be	71271		NA.	NA.	NA.	NA.	NA	NA.	NA.
	palso for more train to plier antum. As seals if I hall more a must selepse from the month of the last societings. NOTE: This edit shall be overridable BMACs: shall deep line-litera on cidims containing HCPCS 71271 when reported more than once in a 12-month passed (11 full more than must always from the month of the last screening) using the following missages:	71271	1x per annum	NA.	NA.	NA.	NA	NA	NA	NA
		71271	1x per annum	NA	NA.	NA.	NA.	15.20	119	N386
	deducible are waived for GCDS AND 71271 for Part B claims and Part A OPPS and non-OPPS claims for TOBs 12X, 13X, 22X, 23X, 71X, 77X, and 85X. This is a conforming change to the aprendinted to align with the implementing January 2021 CR 12356. No action is necessary. THIS IS NOVEMENTAL ONLY.	G0296 71271								
	BIMACs: shall deny line-items on claims containing HCPCS 02296 or 71271 when the basefulary is not between ages 55-77, (Effective 21022 ages 55-77) using the following researces	G0296 71271	Age 55-77 2/5/15-2/9/22 Age 50-77 2/10/22-P	NA.	NA.	NA.	NA.	15.20	6	NA
	BIMACs & MCS: Effective with DOS on and after 25/15, shall allow payment for HCPCS G0296 and 71271 only when billed with ICD-19 Z87.891, OR F17.210, F17.211, F17.213, F17.218, F17.219.	G0296 71271		NA.	NA.	NA.	NA.	NA.	NA.	NA
	BIMACs: shall deny payment for HCPCS 00296 and 71271 only when not billed with ICD-10 Z87.891 OR F17.210, F17.211, F17.213, F17.218, or F17.219.	G0296 71271		NA.	NA.	NA.	NA	15.19	167	N386
Revision history	CR246: For CD-10, all adding implemented with CR2246 except as CR2546: Add ICD-10 dx codes to denote current smoker per public	dition of F17- c		25 to allow 218, F17.2		CS edit 058L	tive for DOS	on and after	25/15.	
	CR12124: Delete expired HCPCS G0297 effective 12/31/20. Add H	CPCS 71271 ef	ective 1/1/21, (FISS RC 324 tert A and Part B OPPS and TONAL ONLY.	71(32472)						spreadsheet
	ussases or cartiviacouses to allon with irreterenting CR 12356 1/ CR12591 Final Decision Memo Effective 2/10/22 reduced acreening	criteria startino	sage from 55 to 50.							