CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12883	**Date: October 11, 2024**
	Change Request 13804

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 18 Section 170.1 and Chapter 32 Section 340.2 for Coding Revisions to the National Coverage Determinations (NCDs) - January 2025 Change Request (CR) 13706

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make updates to chapter 18, section 170.1 and chapter 32, section 340.2 of the Medicare Claims Processing Manual Pub. 100-04 to coincide with the NCD updates in CR 13706, "International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) and Update to the Appropriate Use Criteria (AUC) Program - January 2025."

EFFECTIVE DATE: January 1, 2025 - See business requirements 13804.1 and 13804.2 for dates.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 16, 2025

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	18/170/170.1/Healthcare Common Procedure Coding System (HCPCS) Codes for Screening for STIs and HIBC to Prevent STIs
R	32/340/340.2/Claims Processing Requirements for Mitral Valve TEER Services on Professional Claims

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: 12883	Date: October 11, 2024	Change Request: 13804

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II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update Pub. 100-04, Chapter 18, section 170.1 and Chapter 32, section 340.2 for the billing requirements of the Medicare Claims Processing Manual. The revision listed below can be found in CR 13706 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - January 2025.

NCD 20.33 Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation: Effective January 1, 2025, ICD-10 codes I34.0 and I34.1 listed as primary, along with clinical trial ICD-10 Z00.6 as secondary, these codes can appear in any position (100-04 Chapter 32. Section 340.2 and 100-03 Chapter1, Part 1, Section 20.33).

NCD 210.10 Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs: Add Current Procedural Terminology (CPT) 0455U (used for combined chlamydia and gonorrhea testing), effective July 1, 2024, and end date CPT 0353U June 30, 2024. (100-04 Chapter 18, Section 170.1 and 100-03 Chapter 1, Part 4, Section 210.10).

B. Policy: No Policy changes.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13804.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 18, Section 170.1.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Note: Add CPT code 0455U effective July 1, 2024, and end date CPT code 0353U June 30, 2024.									
13804.2	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 32, Sections 340.2. Note: ICD-10 codes I34.0, I34.1 and Z00.6, can be in any position. This change only pertains to the deletion of primary/secondary verbiage for these codes for NCD 20.33 effective January 1, 2025.	X	X							

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

VI. CONTACTS

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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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 18 - Preventive and Screening Services

Table of Contents
(Rev. 12883; Issued: 10-11-24)

170.1 - Healthcare Common Procedure Coding System (HCPCS) Codes for Screening for STIs and HIBC to Prevent STIs

(Rev. 12883, Issued: 10-11-24; Effective: 01-01-25; Implementation: 01-16-25)

Effective for claims with dates of service on and after November 8, 2011, the claims processing instructions for payment of screening tests for STI will apply to the following HCPCS/CPT codes:

- Chlamydia:
  86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800
  0353U- effective 10/01/22 - *end date 06/30/24* (used for combined chlamydia and gonorrhea testing)
  0402U – effective 10/01/23 (used for combined chlamydia and gonorrhea testing)
  0455U – effective 07/01/24 (used for combined chlamydia and gonorrhea testing)

- Gonorrhea:
  87590, 87591, 87850, 87800
  0353U - effective 10/01/22 - *end date 06/30/24* (used for combined chlamydia and gonorrhea testing)
  0402U – effective 10/01/23 (used for combined chlamydia and gonorrhea testing)
  0455U – effective 0701/24 (used for combined chlamydia and gonorrhea testing)

- Syphilis: 86592, 86593, 86780

- Hepatitis B: (hepatitis B surface antigen): 87340, 87341

Effective for claims with dates of service on and after November 8, 2011, implemented with the January 2, 2012, IOCE, the following HCPCS code is to be billed for HIBC to prevent STIs:

- G0445 - high-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

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(Rev. 12883; Issued: 10-11-24)

340.2 – Claims Processing Requirements for Mitral Valve TEER Services on Professional Claims
(*Rev. 12883; Issued: 10-11-25; Effective: 01-01-25; Implementation: 01-16-25)*

Professional Claims Place of Service (POS) Codes for Mitral Valve TEER Claims
Effective for claims with dates of service on and after August 7, 2014, place of service (POS) code 21 shall be used for mitral valve TEER services. All other POS codes shall be denied.

The following messages shall be used when Medicare contractors deny mitral valve TEER claims for POS:

Claim Adjustment Reason Code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

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.)
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."

Professional Claims Modifiers for Mitral Valve TEER Claims

Effective for claims with dates of service on or after August 7, 2014, contractors shall pay claim lines for mitral valve TEERs billed with the most recent CPT codes 33418, 33419, and 0345T in a clinical trial when billed with modifier -Q0. Mitral valve TEER claim lines in a clinical trial billed without modifier -Q0 shall be returned as unprocessable.

The following messages shall be used when Medicare contractors return mitral valve TEER claim lines in a clinical trial billed without modifier -Q0 as unprocessable:

CARC 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."

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

Professional Clinical Trial Diagnostic Coding for Mitral Valve TEER Claims

Effective for claims with dates of service on or after August 7, 2014 contractors shall pay claim lines for mitral valve TEERs billed with the most recent CPT codes 33418, 33419 and 0345T in a clinical trial when billed with the most recent ICD-10 diagnosis codes ICD-10 I34.0 or I34.1 and Z00.6. Mitral valve TEER claim lines in a clinical trial billed without ICD-10 diagnosis code I34.0 or I34.1 and Z00.6 shall be denied.
**Note: Effective 01/01/25, ICD-10 I34.0 or I34.1 codes are no longer required to be listed as primary, along with clinical trial ICD-10 Z00.6 as secondary. These codes can be reported in any position. See IOM 100-03-chapter 1, section NCD 20.33 for additional information.*
The following messages shall be used when Medicare contractors deny mitral valve TEER claim lines in a clinical trial billed without ICD-10 diagnosis code Z00.6:

CARC 50: These are non-covered services because this is not deemed a “medical necessity” by the payer.

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 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.)

MSN 15.20: The following policies [NCD 20.33]] were used when we made this decision

Spanish Version: MSN 15.20: Las siguientes políticas [NCD 20.33] fueron utilizadas cuando se tomó esta decisión.

Mandatory National Clinical Trial (NCT) Number for Mitral Valve TEER Claims

Effective for claims with dates of service on or after August 7, 2014, contractors shall pay mitral valve TEER claim lines billed with the most recent CPT codes 33418, 33419, and 0345T in a clinical trial only when billed with an 8-digit national clinical trial (NCT) number. Contractors shall accept the numeric, 8-digit NCT number preceded by the two alpha characters of “CT” when placed in Field 19 of paper Form CMS-1500, or when entered WITHOUT the “CT” prefix in the electronic 837P in Loop 2300 REF02 (REF01=P4). **NOTE**: The “CT” prefix is required on a paper claim, but it is not required on an electronic claim. Mitral valve TEER claim lines in a clinical trial billed without an 8- digit NCT number shall be returned as unprocessable.

The following messages shall be used when Medicare contractors return mitral valve TEER claim lines as unprocessable when billed without an 8-digit NCT number:

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

RARC MA50: “Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.”

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.)