CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3146	**Date: December 11, 2014**
	Change Request 8874

Transmittal 3094, dated October 10, 2014, is being rescinded and replaced by Transmittal 3146 to: replace HCPCS code 77057 with code G0202 when used in conjunction with code 77063, remove codes 77061 and 77062 throughout, delete "B" MAC and MCS responsibilities in BR 8874.13.1, changed "return as unprocessable" to "deny" and add MCS responsibility in BR 8874.13.2, replaced RARC N30 with N386 in BR 8874.2.2 and in BR 8874.13.2, added MSN message 14.9 to BR 8874.13.2, added Group Codes CO and PR to BR 8874.13.2, and deleted requirements 8874.12.1, 8874.18, and 8874.18.1. Language in Background and Policy has been revised for clarity. Conforming changes to the manual instruction have also been made including adding codes G0473 and G0279, and updating the description for codes G0202, G0204. and G0206. Additionally, this CR is no longer Sensitive/Controversial. All other information remains the same.

SUBJECT: Preventive and Screening Services — Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to ensure accurate program payment for three screening services for which the beneficiary should not be charged the coinsurance or deductible. The coinsurance and deductible for these services are currently waived, but due to coding changes and additions to the Medicare Physician Fee Schedule Database, the payments for CY 2015 would not be accurate without this CR for intensive behavioral group therapy for obesity, digital breast tomosynthesis, and anesthesia associated with colorectal cancer screening tests.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/Table of Contents
R	18/1.2/Table of Preventive and Screening Services
R	18/20.2/HCPCS and Diagnosis for Mammography Services
N	18/20.2.2/Screening Digital Tomosynthesis

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	18/20.2.3/Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
R	18/60.1/Payment
R	18/60.1.1/Deductible and Coinsurance
R	18/200.1/Policy
R	18/200.2/Institutional Billing Requirements
R	18/200.3/Professional Billing Requirements
R	18/200.4/Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
R	18/200.5/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 obliged 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: 3146	Date: December 11, 2014	Change Request: 8874

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SUBJECT: Preventive and Screening Services - Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy

EFFECTIVE DATE: January 1, 2015
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I. GENERAL INFORMATION

A. Background: Intensive Behavioral Therapy for Obesity

Intensive behavioral therapy for obesity became a covered preventive service under Medicare, effective November 29, 2011. It is reported with HCPCS code G0447 (Face-to-face behavioral counseling for obesity, 15 minutes). Coverage requirements are delineated in the Medicare National Coverage Determinations Manual, Pub. 100-03, chapter 1, section 210.

To improve payment accuracy, in the CY 2015 PFS Proposed Rule, CMS is creating a new HCPCS code for the reporting and payment of behavioral group counseling for obesity and in the CY 2015 PFS Final Rule with comment period, CMS finalized this proposal and added HCPCS code G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes) to the Medicare Physician Fee Schedule Database. For coverage requirements of these services, see the National Coverage Determination for Intensive Behavioral Therapy for Obesity.

Screening Digital Breast Tomosynthesis

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over age 40 and waives the Part B deductible. Screening mammography has been assigned a "B" rating from the United States Preventive Services Task Force (USPSTF) for women every 1 to 2 years for those 40 years and older. Due to the Affordable Care Act amendments to section 1833(a)(1) of the Act, the coinsurance for mammography services is waived as well.

In the CY 2015 PFS Final Rule with comment period, CMS is establishing a payment rate for the newly created CPT code 77063 for screening digital breast mammography. The same policies that are applicable to other mammography should be applicable to CPT code 77063. In addition, since this is an add-on code it should only be paid when furnished in conjunction with a 2D digital mammography. Accordingly, we are will only pay for this code when furnished with G0202.

Anesthesia furnished in conjunction with Colonoscopy

Section 4104 of the Affordable Care Act defined the term "preventive services" to include "colorectal cancer screening tests" and as a result it waives any coinsurance that would otherwise apply under section 1833(a)(1) of the Act for screening colonoscopies. In addition, the Affordable Care Act amended section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies. These provisions are effective for services furnished on or after January 1, 2011.

In the CY 2015 PFS Proposed Rule, CMS proposed to revise the definition of "colorectal cancer screening tests" to include anesthesia separately furnished in conjunction with screening colonoscopies and in the CY 2015 PFS Final Rule with comment period, CMS finalized this proposal. The definition of "colorectal cancer screening tests" includes anesthesia separately furnished in conjunction with screening colonoscopies in the Medicare regulations at §410.37(a)(1)(iii). As a result, beneficiary coinsurance and deductible does not apply to anesthesia services associated with screening colonoscopies.

B. Policy: Intensive Behavioral Therapy for Obesity

Effective for claims with dates of service January 1, 2015 and after, the practitioner furnishing intensive behavioral therapy for obesity in a group setting shall report the relevant group code for each beneficiary participating in a group therapy session. The qualified practitioner furnishing these services shall report HCPCS code G0473 when furnishing these services to a maximum group of ten beneficiaries.

Coinsurance and Deductible

Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with the following HCPCS code G0473: Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)

Screening Digital Breast Tomosynthesis

Effective January 1, 2015, HCPCS code 77063 (Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)), must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2 D imaging only.

Coinsurance and Deductible

Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with the following HCPCS codes:

- 77063: Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)

Anesthesia furnished in conjunction with Colonoscopy Effective January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a screening colonoscopy shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:

- *Modifier 33 – Preventive Services:* when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as

preventive, the modifier should not be used.

Coinsurance and Deductible

Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to the following anesthesia claim lines when furnished in conjunction with screening colonoscopy services and when billed with Modifier 33:

- 00810: Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum

NOTE: New codes will be effective January 1, 2015, and will appear in the January 2015 updates of the Medicare Physician Fee Schedule Database (MPFSDB) and the Integrated Outpatient Code Editor (IOCE).

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	
8874.1	Effective for claims with dates of service on or after January 1, 2015, contractors shall recognize HCPCS codes G0473, Face-to-Face Behavioral Counseling for Obesity, group (2-10), 30 minute(s).	X	X			X			X	IOCE
8874.2	Contractors shall allow payment of HCPCS code G0473 only when billed with one of the ICD-9 codes for BMI 30.0 and over (V85.30-V85.39, V85.41-V85.45). **NOTE:** Contractors shall note that the appropriate ICD- 10 code(s) are listed below. Contractors shall track the ICD-10 code/edits (and add the code(s)/edit(s) to their system when applicable) and ensure that the updated edit is functional as part of the ICD-10 implementation. **NOTE: You will not receive a separate Change Request instructing you to implement updated edits.** BMI 30.0 and over – Z68.30-Z68.39, Z68.41- Z68.45.	X	X			X	X		X	
8874.2.1	Effective for claims with dates of service on or after January 1, 2015, contractors shall deny claims lines for HCPCS code G0473 that are not submitted with one of the diagnosis codes listed in 8874.2.	X	X			X	X			
8874.2.2	Contractors shall deny claim lines for HCPCS codes	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	G0473 that are not submitted with the diagnosis codes listed in BR 8874.2 using the following messages: Claim Adjustment Reason Code (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. Remittance Advice Remark Code (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. Medicare Summary Notice (MSN) 14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim. 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). **NOTE:** For claim lines submitted with modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.									
8874.3	Effective for claims with dates of service on or after January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with HCPCS code G0473.	X	X			X	X		X	
8874.4	Effective for claims with dates of service on or after		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	January 1, 2015, contractors shall pay claims for HCPCS codes G0473 when services are submitted by the following provider specialty types found on the provider's enrollment record: 01 - General Practice 08 - Family Practice 11- Internal Medicine 16 - Obstetrics/Gynecology 37 – Pediatric Medicine 38 – Geriatric Medicine 50 - Nurse Practitioner 89 - Certified Clinical Nurse Specialist 97 - Physician Assistant									
8874.4.1	Contractors shall deny claim lines for HCPCS code G0473 performed by provider specialty types other than those specified in BR 8874.4 using the following: CARC 8 - The procedure code is inconsistent with the provider type/specialty (taxonomy). 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 21.18 - This item or service is not covered when performed or ordered by this provider. Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	ABN is on file). **NOTE:** For claim lines submitted with modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.									
8874.5	Effective for claims with dates of service on or after January 1, 2015, contractors shall pay for obesity counseling claims containing HCPCS codes G0473 only when services are provided with the following place of service (POS) codes: 11 – Physician's Office 22 – Outpatient Hospital 49- Independent Clinic 71 - State or local public health clinic		X							
8874.5.1	Contractors shall deny claim lines for HCPCS code G0473 submitted without the appropriate POS code using the following: CARC 5 - The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC M77 - Missing/incomplete/invalid place of service. MSN 21.25 - This service was denied because Medicare only covers this service in certain settings. 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 claim lines submitted with modifier GZ, use CARC 50 and MSN 8.81 per instructions in		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CR 7228/TR 2148.									
8874.6	Effective for claims with dates of service on or after January 1, 2015, the contractor shall allow a total of no more than 22 sessions of obesity counseling, codes G0447 and G0473, in a 12-month period. **NOTE:** The contractor shall count from the date of the 1st G0447 or G0473 claim received date. Eleven full months must pass from the month of the 1st G0447 or G0473 claim received date before another round of 22 sessions could begin, i.e., July 15, 2015 begins the count so July 1, 2016 another round could begin (based on NCD criteria).								X	
8874.6.1	The contractor shall reject more than 22 submissions of HCPCS codes G0447 and G0473, in a 12-month period.					X			X	
8874.6.2	Contractors shall deny claim lines for HCPCS codes G0447 and G0473 if billed more than 22 times, in a 12-month period using the following: 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. 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.” 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	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	ABN is on file). **NOTE:** For claim lines submitted with modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.									
8874.6.3	When applying frequency limitations required in BR 8874.6 the contractor shall allow both a claim for the professional service and a claim for a facility fee. **NOTE:** Part B/HUBC claims will process as professional claims.								X	
8874.7	The contractor shall identify the following institutional claims as facility fee claims for obesity screening services, HCPCS codes G0473: • TOB 13X • TOB 85X when the revenue code is not 096X, 097X, or 098X								X	
8874.7.1	The contractor shall identify all other claims as professional service claims for obesity screening services, HCPCS codes G0473, (professional claims, and institutional claims with TOB 85X when the revenue code is 096X, 097X, or 098X).								X	
8874.8	Contractors shall pay for HCPCS codes G0473 on institutional claims in hospital outpatient departments TOB 13X based on OPPS and in critical access hospitals TOB 85X based on reasonable cost. Deductible and coinsurance do not apply.	X								
8874.8.1	Contractors shall pay for HCPCS codes G0473 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the fee schedule amount or submitted charge. Deductible and coinsurance do not apply.	X								
8874.8.2	Contractors shall line-item deny any claim submitted with obesity counseling HCPCS codes G0473 when	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the TOB is not 13X or 85X with the following: 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 this place of service. MSN 16.2 - This service cannot be paid when provided in this location/facility. 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). **NOTE:** For claim lines submitted with modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.									
8874.9	The contractor shall calculate a next eligible date for obesity counseling G0473 for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status • Beneficiary claims history • Utilization rules **NOTE:** The calculation for the next eligible date for obesity counseling shall parallel claims processing.								X	MBD, NGD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8874.9.1	The next eligible date shall be displayed on all contractor provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).					X			X	MBD, NGD
8874.9.1.1	When there is no ‘next eligible date’ the contractor shall display information in the date field to indicate why there is no ‘next eligible date.’								X	MBD, NGD, PRVN
8874.9.1.2	Any change to beneficiary master data or claims data that would result in a change to any ‘next eligible’ date shall result in an update to the beneficiary’s ‘next eligible date.’								X	MBD, NGD, PRVN
8874.10	Effective for claims with dates of service on or after January 1, 2015, contractors shall continue to recognize and pay HCPCS code 00810, Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum.	X	X			X				
8874.10.1	Effective for claims with dates of service on or after January 1, 2015, contractors shall update their systems to recognize, accept, and be capable of processing modifier 33 for appropriate claims processing purposes. **NOTE:** Coinsurance and deductible shall be waived, effective January 1, 2015, only for HCPCS anesthesia code 00810 billed with modifier 33 when these anesthesia services are performed in conjunction with screening colonoscopy services HCPCS G0105 and G0121.	X	X			X			X	
8874.10.1.1	Effective for claims with dates of service on or after January 1, 2015, contractors shall not apply deductible and coinsurance to claim lines for HCPCS 00810 services when billed with modifier 33.	X	X			X				
8874.10.1.2	Effective with dates of service on or after January 1, 2015, contractors shall continue to apply deductible and coinsurance to claim lines HCPCS 00810 services billed without modifier 33.	X	X			X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8874.11	Effective for claims with dates of service on or after January 1, 2015, contractors shall recognize HCPCS code 77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	X	X			X			X	IOCE
8874.12	Effective for claims with dates of service on or after January 1, 2015, beneficiary coinsurance and deductible do not apply to claim lines with HCPCS code 77063.	X	X			X			X	
8874.12.1	This requirement deleted.									
8874.13	Contractors shall allow payment for HCPCS code 77063 only when billed with one of the ICD-9 codes for mammography: • V76.11 or • V76.12 **NOTE:** Contractors shall note that the appropriate ICD- 10 code(s) are listed below. Contractors shall track the ICD-10 code/edits (and add the code(s)/edit(s) to their system when applicable) and ensure that the updated edit is functional as part of the ICD-10 implementation. **NOTE: You will not receive a separate Change Request instructing you to implement updated edits.** Encounter for screening mammogram for malignant neoplasm of breast – Z12.31.	X	X			X	X		X	
8874.13.1	Effective for claims with dates of service on or after January 1, 2015, contractors shall RTP/return as unprocessable claims for HCPCS code 77063 that are not submitted with one of the diagnosis codes listed in BR 8874.13.	X				X				
8874.13.2	Effective for claims with dates of service on or after January 1, 2015, contractors shall deny claims lines for HCPCS code 77063 that are not submitted with the diagnosis codes listed in BR 8874.13 using the following messages:		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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. Remittance Advice Remark Code (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 14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim. 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).									
8874.14	Effective for claims with dates of service on or after January 1, 2015, contractors shall add tomosynthesis, code 77063 to current age and frequency edits for screening mammography.								X	
8874.15	Effective for claims with dates of service on or after January 1, 2015, contractors shall allow payment for HCPCS code 77063 only when billed in conjunction with HCPCS code G0202.	X	X				X		X	
8874.15.1	Effective for claims with dates of service on or after January 1, 2015, contractors shall deny claims for HCPCS code 77063 that are not submitted in conjunction with HCPCS code G0202. **NOTE:** Contractors shall use existing reason codes when add-on codes are billed alone.	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8874.16	Contractors shall pay for tomosynthesis, HCPCS code 77063, on institutional claims TOBs 12X, 13X, 22X, 23X based on MPFS, and TOB 85X with revenue code other than 096x, 097x, or 098x based on reasonable cost. TOB 85X claims with revenue code 096x, 097x, or 098x are paid based on MPFS (115% of the lesser of the fee schedule amount and submitted charge).	X				X				
8874.16.1	Contractors shall pay for tomosynthesis, HCPCS code 77063 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the fee schedule amount or submitted charge.	X								
8874.16.2	Contractors shall return to the provider any claim submitted with tomosynthesis, HCPCS code 77063 when the TOB is not 12X, 13X, 22X, 23X, or 85X.	X								
8874.17	Contractors shall pay for tomosynthesis, HCPCS code 77063, on institutional claims TOBs 12X, 13X, 22X, 23X, and 85X when submitted with revenue code 0403 and on professional claims TOB 85X when submitted with revenue code 096X, 097X, or 098X.	X								
8874.17.1	Effective for claims with dates of service on or after January 1, 2015, contractors shall RTP claims for HCPCS code 77063 that are not submitted with revenue code 0403, 096X, 097X, or 098X.	X				X				
8874.18	This requirement deleted.									
8874.18.1	This requirement deleted.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8874.19	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

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): Thomas Dorsey, Thomas.Dorsey@cms.hhs.gov (Professional Claims Processing), William Ruiz, William.Ruiz@cms.hhs.gov (Institutional Claims Processing), Donta Henson, Donta.Henson@cms.hhs.gov (Policy)

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 18 - Preventive and Screening Services

Table of Contents
(Rev. 3146, Issued: 12-11-14)

20.2.2 - Screening Digital Breast Tomosynthesis

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

1.2 – Table of Preventive and Screening Services

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	***Not Rated**	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	**B**	WAIVED
Cardiovascular Disease Screening	80061	Lipid panel	**A**	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	**B**	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	***Not Rated**	WAIVED
Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	***Not Rated**	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	**B**	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	**B**	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	**A**	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	**A**	WAIVED
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	**A**	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	**A**	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	**A**	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	**A**	WAIVED
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	**A**	WAIVED
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED
	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	**A**	WAIVED
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	**B**	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	**B**	WAIVED
	77063	*Screening digital breast tomosynthesis, bilateral*		*WAIVED*
	G0202	Screening mammography, producing direct *2-D* digital image, bilateral, all views		WAIVED
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	**B**	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77083	Radiographic absorptiometry (e.g., photo densitometry, radiogrammetry), 1 or more sites		WAIVED
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED
NOTE: *For Colorectal Cancer Screening, effective January 1, 2015, when anesthesia service G0810 are performed in conjunction with screening colonoscopy services G0105 or G0121, coinsurance and deductible will be waived for anesthesia service 00810 when modifier 33 is entered on the anesthesia claim.*				
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	**A**	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	***Not Rated**	Coins. Applies & Ded. is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coins. Applies & Ded. is waived
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	**A**	WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	**D**	Not Waived
	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	**I**	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived
Influenza Virus Vaccine	90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use	**B**	WAIVED
	90654	Influenza virus vaccine, split virus, preservative free, for intradermal use, for adults ages 18-64		WAIVED
	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use		WAIVED
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED
	90672	Influenza virus vaccine, live, quadrivalent, for intranasal use		WAIVED
	90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Pneumococcal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	**B**	WAIVED
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use.		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
Hepatitis B Vaccine	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	**A**	WAIVED
	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use		WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	G0010	Administration of Hepatitis B vaccine	**A**	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Hepatitis C Virus Screening	*G0472*	*Screening for Hepatitis C antibody*	***B***	*WAIVED*
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple-step method, HIV-1 or HIV-2, screening	**A**	WAIVED
	G0433	Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED
	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2 , screening		WAIVED
Smoking Cessation	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	***Not Rated**	WAIVED
	G0439	Annual wellness visit, including PPPS, subsequent visit		WAIVED
Intensive Behavioral Therapy for Obesity	*G0447*	*Face-to-Face Behavioral Counseling for Obesity, 15 minutes*	*B*	*WAIVED*
	G0473	*Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)*		

20.2 - HCPCS and Diagnosis Codes for Mammography Services

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

The following HCPCS codes are used to bill for mammography services.

HCPCS Code	**Definition**
77051* (76082*)	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography (list separately in addition to code for primary procedure). **Code 76082 is effective January 1, 2004 thru December 31, 2006. Code 77051 is effective January 1, 2007.**
77052* (76083*)	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography (list separately in addition to code for primary procedure). **Code 76083 is effective January 1, 2004 thru December 31, 2006. Code 77052 is effective January 1, 2007.**
77055* (76090*)	Diagnostic mammography, unilateral.
77056* (76091*)	Diagnostic mammography, bilateral.
77057* (76092*)	Screening mammography, bilateral (two view film study of each breast).
*77063***	*Screening Breast Tomosynthesis; bilateral (list separately in addition to code for primary procedure).*
G0202	Screening mammography, producing direct *2-D* digital image, bilateral, all views. **Code is effective April 1, 2001.** ***This code descriptor effective January 1, 2015***
G0204	Diagnostic mammography, direct *2-D* digital image, bilateral, all views. **Code is effective April 1, 2001.** ***This code descriptor is effective January 1, 2015***
G0206	Diagnostic mammography, producing direct *2-D* digital image, unilateral, all views**. Code is effective April 1, 2001.** This code descriptor is effective January 1, 2015.
*G0279***	*Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206)*

*****NOTE:** HCPCS codes 77063 and G0279 are effective for claims with dates of service on or after January 1, 2015.*

*****For claims with dates of service prior to January 1, 2007, providers report CPT codes 76082, 76083, 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.

New Modifier "-GG": Performance and payment of a screening mammography and diagnostic mammography on same patient same day - This is billed with the Diagnostic Mammography code to show the test changed from a screening test to a diagnostic test. Contractors will pay both the screening and diagnostic mammography tests. This modifier is for tracking purposes only. This applies to claims with dates of service on or after January 1, 2002.

A. Diagnosis for Services On or After January 1, 1998

The BBA of 1997 eliminated payment based on high-risk indicators. However, to assure proper coding, one of the following diagnosis codes should be reported on screening mammography claims as appropriate:

V76.11 – "Special screening for malignant neoplasm, screening mammogram for high-risk patients" or;

V76.12 - "Special screening for malignant neoplasm, other screening mammography."

Beginning October 1, 2003, *A/B MACs* are no longer permitted to plug the ICD-9-CM code for a screening mammography when the screening mammography claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.

Providers report diagnosis code V76.11 or V76.12 in "Principal Diagnosis Code" if the screening mammography is the only services reported on the claim. If the claim contains other services in addition to the screening mammography, diagnostic codes V76.11 or V76.12 are reported, as appropriate, in "Other Diagnostic Codes." **NOTE:** Information regarding the form locator number that corresponds to the principal and other diagnosis codes and a table to crosswalk the CMS-1450 form locator to the 837 transaction is found in Chapter 25.

A/B MACs (B) receive this diagnosis in field 21 and field 24E with the appropriate pointer code of Form CMS-1500 or in Loop 2300 of ANSI- X12 837.

Diagnosis codes for a diagnostic mammography will vary according to diagnosis.

B. Diagnoses for Services October 1, 1997 Through December 31, 1997

On every screening mammography claim where the patient is not a high-risk individual, diagnosis code V76.12 is reported on the claim.

If the screening is for a high risk individual, the provider reports the principal diagnosis code as V76.11 - "Screening mammogram for high risk patient."

In addition, for high-risk individuals, one of the following applicable diagnoses codes is reported as "Other Diagnoses codes":

- V10.3 "Personal history - Malignant neoplasm female breast";

- V16.3 “Family history - Malignant neoplasm breast”; or
- V15.89 “Other specified personal history representing hazards to health.”

The following chart indicates the ICD-9 diagnosis codes reported for each high-risk category:

High Risk Category	Appropriate Diagnosis Code
A personal history of breast cancer	V10.3
A mother, sister, or daughter who has breast cancer	V16.3
Not given birth prior to age 30	V15.89
A personal history of biopsy-proven benign breast disease	V15.89

20.2.2 – Screening Digital Breast Tomosynthesis

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

Effective with claims with dates of service January 1, 2015 and later, HCPCS code 77063, “Screening Digital Breast Tomosynthesis, bilateral, must be billed in conjunction with the primary service mammogram code G0202.

Contractors must assure that claims containing code 77063 also contain HCPCS code G0202. A/B MACs (A) return claims containing code 77063 that do not also contain HCPCS code G0202 with an explanation that payment for code 77063 cannot be made when billed alone. A/B MACs (B) deny payment for 77063 when billed without G0202.

NOTE: *When screening digital breast tomosynthesis, code 77063, is billed in conjunction with a screening mammography, code G0202, and the screening mammography G0202 fails the age and frequency edits in CWF, both services will be rejected by CWF.*

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

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

When denying claim lines for HCPCS code 77063 that are not submitted with the diagnosis code V76.11 or V76.12 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.

MSN 14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim.

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).

60.1 - Payment

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

Payment is under the MPFS except as follows:

- Fecal occult blood tests (82270* (G0107*) and G0328) are paid under the clinical diagnostic lab fee schedule except reasonable cost is paid to all non-OPPS hospitals, including CAHs, but not IHS hospitals billing on TOB 83x. IHS hospitals billing on TOB 83x are paid the ASC payment amount. Other IHS hospitals (billing on TOB 13x) are paid the OMB approved AIR, or the facility specific per visit amount as applicable. Deductible and coinsurance do not apply for these tests. See section A below for payment to Maryland waiver on TOB 13X. Payment *to* all hospitals for non-patient laboratory specimens on TOB 14X will be based on the clinical diagnostic fee schedule, including CAHs and Maryland waiver hospitals.

- Flexible sigmoidoscopy (code G0104) is paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs; or current payment methodologies for hospitals not subject to OPPS.

- Colonoscopies (G0105 and G0121) and barium enemas (G0106 and G0120) are paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs or current payment methodologies for hospitals not subject to OPPS. Also colonoscopies may be done in an Ambulatory Surgical Center (ASC) and when done in an ASC the ASC rate applies. The ASC rate is the same for diagnostic and screening colonoscopies. The ASC rate is paid to IHS hospitals when the service is billed on TOB 83x.

The following screening codes must be paid at rates consistent with the *rates of the* diagnostic codes indicated. Coinsurance and deductible *apply to diagnostic codes.*

Screening Code	Diagnostic Code
G0104	45330
G0105 and G0121	45378
G0106 and G0120	74280

A. Special Payment Instructions for TOB 13X Maryland Waiver Hospitals

For hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission, screening colorectal services HCPCS codes G0104, G0105, G0106, 82270* (G0107*), G0120, G0121 and G0328 are paid according to the terms of the waiver, that is 94% of submitted charges minus any unmet existing deductible, co-insurance and non-covered charges. Maryland Hospitals bill TOB 13X for outpatient colorectal cancer screenings.

B. Special Payment Instructions for Non-Patient Laboratory Specimen (TOB 14X) for <u>all</u> hospitals

Payment for colorectal cancer screenings (82270* (G0107*) and G0328) to a hospital for a non-patient laboratory specimen (TOB 14X), is the lesser of the actual charge, the fee schedule amount, or the National Limitation Amount (NLA), (including CAHs and Maryland Waiver hospitals). Part B deductible and coinsurance do not apply.

***NOTE:** For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with CPT code 82270.

60.1.1 – Deductible and Coinsurance

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

There is no deductible and no coinsurance or copayment for the fecal occult blood tests (G0107 and G0328), *flexible sigmoidoscopy (G0104), colonoscopy on individual at high risk (G0105), and colonoscopy on individual not meeting criteria of high risk (G0121).*

Prior to January 1, 2007 deductible and coinsurance apply to other colorectal procedures (G0106 and G0120). After January 1, 2007, the deductible is waived for those tests. *Coinsurance applies.*

Effective January 1, 2015, coinsurance and deductible are waived for anesthesia services HCPCS Code 00810, Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum, when performed for screening colonoscopy services and when billed with Modifier 33.

NOTE: A 25 percent coinsurance applies for all colorectal cancer screening colonoscopies (G0105 and G0121) performed in ASCs and non-OPPS hospitals effective for services performed on or after January 1, 2007. The 25 percent coinsurance was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

A 25 percent coinsurance also applies for colorectal cancer screening sigmoidoscopies (G0104) performed in non-OPPS hospitals effective for services performed on or after January 1, 2007. Beginning January 1, 2008, colorectal cancer screening sigmoidoscopies (G0104) are payable in ASCs, and a 25 percent coinsurance applies. The 25 percent coinsurance for colorectal cancer screening sigmoidoscopies was implemented in OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

200.1 – Policy

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

For services furnished on or after November 29, 2011, *Medicare* will cover Intensive Behavioral Therapy for Obesity. Medicare beneficiaries with obesity (BMI $\geq$30 kg/m^2) who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting are eligible for:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months as discussed below.

The counseling sessions are to be completed based on the 5As approach adopted by the USPSTF. The steps to the 5As approach are listed below:

1. **Assess**: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.

2. **Advise**: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.

3. **Agree**: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.

4. **Assist**: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.

5. **Arrange**: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Medicare will cover Face-to-Face Behavioral Counseling for Obesity, 15 minutes *(*G0447*)*, *Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473)*, along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), up to 22 sessions in a 12-month period for Medicare beneficiaries. The Medicare coinsurance and Part B deductible are waived for this preventive service.

***NOTE**: Effective for claims with dates of service on or after January 1, 2015, codes G0473 and G0447 can be billed for a total of no more than 22 sessions in a 12-month period.*

Contractors shall note the appropriate ICD-10 code(s) that are listed below for future implementation. Contractors shall track the ICD-10 codes and ensure that the updated edit is turned on *when ICD-10 is implemented.*

ICD-10	Description
Z68.30	BMI 30.0-30.9, adult
Z68.31	BMI 31.0-31.9, adult
Z68.32	BMI 32.0-32.9, adult
Z68.33	BMI 33.0-33.9, adult
Z68.34	BMI 34.0-34.9, adult
Z68.35	BMI 35.0-35.9, adult
Z68.36	BMI 36.0-36.9, adult
Z68.37	BMI 37.0-37.9, adult
Z68.38	BMI 38.0-38.9, adult
Z68.39	BMI 39.0-39.9, adult
Z68.41	BMI 40.0-44.9, adult
Z68.42	BMI 45.0-49.9, adult
Z68.43	BMI 50.0-59.9, adult
Z68.44	BMI 60.0-69.9, adult
Z68.45	BMI 70 or greater, adult

See Pub. *100-03, Medicare* National Coverage Determinations Manual, §210.12 for complete coverage guidelines.

200.2 – Institutional Billing Requirements

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

Effective for claims with dates of service on and after November 29, 2011, providers may use the following types of bill (TOB) when submitting HCPCS code G0447: 13x, 71X, 77X, or 85X. Service line items on other TOBs shall be denied.

Effective for claims with dates of service on and after January 1, 2015, providers may use the following types of bill (TOB) when submitting HCPCS code G0473: 13x or 85X. Service line items on other TOBs shall be denied.

The service shall be paid on the basis shown below:

- Outpatient hospitals – TOB 13X - based on Outpatient Prospective Payment System (OPPS)
- Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost
- CAH Method II – TOB 85X - based on 115% of the lesser of the Medicare Physician Fee Schedule (MPFS) amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

NOTE: For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

200.3 – Professional Billing Requirements

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, *(*G0447*), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473),* along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), only when services are submitted by the following provider specialties found on the provider's enrollment record:

01 - General Practice
08 - Family Practice
11 - Internal Medicine
16 - Obstetrics/Gynecology
37 - Pediatric Medicine
38 - Geriatric Medicine
50 - Nurse Practitioner
89 - Certified Clinical Nurse Specialist
97 - Physician Assistant

Any claims that are not submitted from one of the provider specialty types noted above will be denied.

CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, *(*G0447*), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473)*, along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), only when submitted with one of the following place of service (POS) codes:

11 – Physician's Office
22 – Outpatient Hospital
49 – Independent Clinic
71 – State or Local Public Health Clinic

Any claims that are not submitted with one of the POS codes noted above will be denied.

NOTE: *HCPCS Code G0447 is effective November 29, 2011. HCPCS Code G0473 is effective January 1, 2015.*

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

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

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 obesity counseling sessions:

- Denying services submitted on a TOB other than 13X and 85X:

  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 this place of service.

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

  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).

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

- Denying services for obesity counseling sessions HCPCS code *G0473 or* G0447 with 1 of the ICD-9 codes (V85.30-V85.39 or V85.41-V85.45) when billed for a total of more than 22 *sessions* in the same 12-month period:

  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.

  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."

  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).

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

- Denying claim lines for obesity counseling sessions HCPCS code *G0473 or* G0447 without 1 of the appropriate ICD-9 codes (V85.30-V85.39 or V85.41-V85.45):

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 14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim.

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).

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

- Denying claim lines without the appropriate POS code:

  CARC 5 - The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC M77 - Missing/incomplete/invalid place of service.

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

  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 that are not submitted from the appropriate provider specialties:

  CARC *8 - The procedure code is inconsistent with the provider type/specialty (taxonomy). 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 21.18 - This item or service is not covered when performed or ordered by this provider.

  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.

200.5 – Common Working File (CWF) Edits

(Rev. 3146, Issued: 12-11-14, Effective: 01-01-15, Implementation: 01-05-15)

When applying frequency, CWF shall count 22 counseling sessions of *any of G0473 and/or* G0447 *(for a total of no more than 22 sessions in the same 12-month period)* along with 1 ICD-9 code from V85.30-V85.39 or V85.41-V85.45 in a 12-month period. When applying frequency limitations to *G0473 or* G0447 counseling CWF shall allow both a claim for the professional service and a claim for a facility fee. CWF shall identify the following institutional claims as facility fee claims for this service: TOB 13X, TOB 85X when the revenue code is not 096X, 097X, or 098X. CWF shall identify all other claims as professional service claims.