CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3374	**Date: October 15, 2015**
	Change Request 9246

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 2, 2015. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform contractors that Medicare covers lung cancer screening with low dose computed tomography (LDCT) if all eligibility requirements listed in the National Coverage Determination (NCD) are met.

EFFECTIVE DATE: February 5, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2016

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/Table of Contents
R	18/1.2/Table of Preventive and Screening Services
N	18/220/Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)
N	18/220.1/Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)
N	18/220.2/Institutional Billing Requirements
N	18/220.3/Deductible and Coinsurance
N	18/220.4/Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
N	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: 3374	Date: October 15, 2015	Change Request: 9246

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SUBJECT: Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

EFFECTIVE DATE: February 5, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2016

I. GENERAL INFORMATION

A. Background: Pursuant to §1861(ddd) of the Social Security Act, the Centers for Medicare and Medicaid Services (CMS) may add coverage of "additional preventive services" through the Medicare National Coverage Determinations (NCD) process. The “additional preventive services” must meet all of the following criteria: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

The CMS reviewed the evidence for lung cancer screening with low dose computed tomography (LDCT) and determined that the criteria listed above were met, enabling CMS to cover this “additional preventive service” under Medicare Part B. Effective February 5, 2015, Medicare covers lung cancer screening with LDCT if all eligibility requirements listed in the NCD are met.

B. Policy: Effective February 5, 2015, CMS has determined that the evidence is sufficient to add a lung cancer screening counseling and shared decision making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT), as an additional preventive service benefit under the Medicare program if all eligibility criteria described in the NCD are met.

For purposes of Medicare coverage of lung cancer screening with LDCT, beneficiaries must meet all of the following eligibility criteria:

- Age 55 – 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and
- Receives a written order for lung cancer screening with LDCT that meets the requirements described in the NCD. Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary’s medical records, and must contain the following information:
- Beneficiary date of birth;
- Actual pack – year smoking history (number);

- Current smoking status, and for former smokers, the number of years since quitting smoking;
- Statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and
- National Provider Identifier (NPI) of the ordering practitioner.

Before the first lung cancer LDCT screening, the beneficiary must receive a lung cancer screening counseling and shared decision making visit, and if appropriate, receive the written order for his/her first lung cancer LDCT screen during such visit. Written orders for subsequent annual LDCT screens may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist) as described in the NCD.

This NCD also establishes data collection requirements and specific coverage eligibility criteria for radiologists and radiology imaging facilities for purposes of Medicare coverage of lung cancer screening with LDCT.

II. 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	
9246 - 04.1	Effective for line-items on claims with dates of service on or after February 5, 2015, contractors shall recognize and add to systems new HCPCS codes G0296- Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making), and G0297 - Low dose CT scan (LDCT) for lung cancer screening, as covered services. NOTE: HCPCS codes G0296 and G0297 are in the January 1, 2016 HCPCS and OPPS updates with an effective date of February 5, 2015, and in the January 2016 IOCE updates with an effective date of February 5, 2015. HCPCS codes G0296 and G0297 are in the 2016 MPFSDB update which is effective for claims with 2016 dates of service. NOTE: Refer to Pub. 100-03, Medicare NCD Manual, chapter 1, section 210.14 for coverage policy, and Pub. 100-04, Claims Processing Manual, Chapter 18, Section 220 for claims processing instructions. Type of Service (TOS)	X	X			X			X	IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	G0296- TOS 1 G0297- TOS 1									
9246 - 04.2	Contractors shall not apply beneficiary coinsurance and deductibles to claim lines containing HCPCS codes G0296 or G0297.		X			X			X	IOCE
9246 - 04.3	Contractors shall create a line-level edit to allow HCPCS code G0297 to be billed no more than once per annum. At least 11 full months must elapse from the date of the last screening. NOTE: This edit shall be overridable.					X			X	
9246 - 04.3.1	Contractors shall deny line-items on claims containing HCPCS code G0297 when reported more than once in a 12-month period (11 full months must elapse from the date of the last screening) using the following messages: Claim Adjustment Reason Code (CARC) 119: "Benefit maximum for this time period or occurrence has been reached." 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) 15.20: "The following policy was used when we made this decision: NCD 210.14"	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Spanish Version – “Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 210.14.” 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.									
9246 - 04.3.2	When denying line-items on claims per requirement 9246-04.3, contractors shall use the following MSN message in addition to MSN 15.20, as well as the CARC/RARC listed in 9246-04.3.1: 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.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9246 - 04.4	Contractors shall create an edit to allow HCPCS codes G0296 or G0297 to be billed only if the beneficiary is between the ages of 55-77.					X			X	
9246 - 04.4.1	Contractors shall deny line-items on claims containing HCPCS code G0296 or G0297 when the beneficiary is not between ages 55-77 using the following messages: CARC 6: "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present." MSN 15.20: "The following policy was used when we made this decision: NCD 210.14." Spanish Version – "Las siguientes políticas NCD 210.14 fueron utilizadas cuando se tomó esta decisión." Group Code: CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). NOTE: For modifier GZ, use CARC 50 and MSN 8.81.	X	X							
9246 - 04.4.2	When denying line-items on claims per requirement 9246-04.4, contractors shall use the following MSN message in addition to MSN 15.20, as well as the CARC/RARC listed in 9246-04.4.1: 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".	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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.									
9246 - 04.5	Contractors shall allow payment for HCPCS codes G0296 and G0297 only when billed with ICD-9 code V15.82 (ICD-10 Z87.891) personal history of tobacco use/personal history of nicotine dependence. NOTE: Contractors shall note that the appropriate ICD- 10 code(s) are listed above. 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.					X	X			
9246 - 04.5.1	Contractors shall deny line-items on claims for HCPCS codes G0296 and G0297 that are not submitted with diagnosis code V15.82 or Z87.891 using 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.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 NCD 210.14 fueron utilizadas cuando se tomó esta decisión." Group Code: CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). NOTE: For modifer GZ, use CARC 50 and MSN 8.81.									
9246 - 04.5.2	When denying line-items on claims per requirement 9246-04.5, contractors shall use the following MSN message in addition to MSN 15.20, as well as the CARC/RARC listed in requirement 9246-04.5.1. 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".	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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.									
9246 - 04.6	Contractors shall pay for HCPCS codes G0296 and G0297 only when submitted on the following types of bill (TOBs): • 12x and 13X, • 22X and 23X, • 71X (G0296 only), • 77X (G0296 only), or • 85X.	X				X				
9246 - 04.6.1	Contractors shall pay for HCPCS codes G0296 and G0297 for the following TOBs on institutional claims as follows: • Hospital outpatient departments (TOBs 12X and 13X) based on OPPS,	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Skilled nursing facilities (TOB 22X and 23X) based on the Medicare Physician Fee Schedule (MPFS), • Critical Access Hospitals (CAHs) (TOB 85X) based on reasonable cost, • Rural Health Clinics (TOB 71X) based on the all-inclusive rate for G0296 only, • Federally Qualified Health Centers (TOB 77X) based on the prospective payment system rate for G0296 only, • CAHs (TOB 85X) Method II with revenue code 096X, 097X, and 098X based on the lesser of the actual charge or the MPFS (115% of the lesser of the fee schedule amount and submitted charge) for G0296 only.									
9246 - 04.6.2	Contractors shall not pay line-items on claims with G0296 on 71X and 77X TOBs when G0296 is billed on the same day with another visit (this does not apply to initial preventive physical exams for 71X TOBs). The service line with G0296 should be shown as covered with the following ANSI information: 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. MSN 16.34 - You should not be billed for this service. You are only responsible for any					X				IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	deductible and coinsurance amounts listed in the 'You May Be Billed' column. NOTE: 77X TOBs will be processed through the IOCE under the current process. Group Code CO assigning financial liability to the provider.									
9246 - 04.6.3	Contractors shall deny line-items on institutional claims containing HCPCS code G0296 when submitted on a TOB other than 12X, 13X, 22X, 23X, 71X, 77X, or 85X using the following messages: 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 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	X								
9246 - 04.6.4	Contractors shall deny line-items on institutional claims containing HCPCS code G0297 when submitted on a TOB other than 12X, 13X, 22X, 23X, or 85X using the following messages:	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 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									
9246 - 04.7	CWF shall calculate a next eligible date for HCPCS code G0297, for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status • Beneficiary claims history								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Utilization rules NOTE: The calculation for preventive services next eligible date shall parallel claims processing.									
9246 - 04.8	The next eligible dates shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, PRVN).					X			X	MBD, NGD
9246 - 04.9	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	
9246 - 04.10	The Multi-Carrier System Desktop Tool (MCSDT) shall display HCPCS code G0297 sessions on a separate screen and in a format equivalent to the CWF HIMR screen.		X				X			
9246 - 04.11	Contractors shall apply contractor pricing to claims containing HCPCS codes G0296 or G0297 with dates of service February 5, 2015, through December 31, 2015.		X							
9246 - 04.12	Contractors shall not search for claims for lung cancer screening counseling and shared decision making visits or claims for lung cancer screening with low dose computed tomography, with dates of service on or after February 5, 2015, but contractors may adjust claims that are brought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9246 - 04.13	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 5 business days after receipt of the notification from CMS announcing the availability of the 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): Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Coverage) , Patricia Brocato-Simons, 410-786-0261 or Patricia.Brocatosimons@cms.hhs.gov (Coverage) , Wendy Knarr, 410-786-0843 or Wendy.Knarr@cms.hhs.gov (Supplier Claims Processing) , William Ruiz, 410-786-9283 or William.Ruiz@cms.hhs.gov (Part A Institutional Claims Processing) , Jamie Hermansen, 410-786-2064 or Jamie.Hermansen@cms.hhs.gov (Coverage) , Thomas Dorsey, 410-786-7434 or Thomas.Dorsey@cms.hhs.gov (Practitioner Claims Processing Part B)

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.3374, Issued: 10-15-15)

1.2 – Table of Preventive and Screening Services

(Rev.3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

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
	82950	Glucose; post glucose dose (includes glucose)		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	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
	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

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
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
	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

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	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
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

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	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
	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 00810 is 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.

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia code 00810 should be submitted with only the PT modifier and only the deductible will be waived.

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
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
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

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	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
	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

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	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
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

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	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
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

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	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)		
Lung Cancer Screening	*G0296*	*Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)*	*B*	*WAIVED*
	G0297	*Low dose CT scan (LDCT) for lung cancer screening*		

220 – Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)
(Rev.3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

Effective for services furnished on or after February 5, 2015, Medicare covers a lung cancer screening counseling and shared decision making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT) if all the eligibility requirements listed in the national coverage determination (NCD) are met.

See Pub.100-03, Medicare NCD Manual, Chapter 1, Section 210.14, for complete coverage requirements.

220.1 – Health Care Common Procedure Coding System (HCPCS) Codes
(Rev.3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

Effective for claims with dates of service on and after February 5, 2015, the following codes are used for lung cancer screening with LDCT services:

G0296 – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)

G0297 – Low dose CT scan (LDCT) for lung cancer screening

220.2 – Institutional Billing Requirements
(Rev.3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

Effective for claims with dates of service on and after February 5, 2015, providers may use the following types of bill (TOBs) when submitting claims for LDCT lung cancer screening, HCPCS codes G0296 and G0297: 12X, 13X, 22X, 23X, and 85X.

Effective for claims with dates of service on and after February 5, 2015, providers may also use the following TOBs when submitting claims for LDCT lung cancer screening, HCPCS code G0296: 71X, 77X, and 85X with revenue code 096X, 097X, and 098X.

The service shall be paid on the basis shown below:

-Outpatient hospital departments – TOBs 12X and 13X - based on Outpatient Prospective Payment System (OPPS),

-Skilled nursing facilities (SNFs) – TOBs 22X and 23X – based on the Medicare Physician Fee Schedule (MPFS),

-Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost,

-CAH Method II – TOB 85X with revenue code 096X, 097X, or 098X based on the lesser of the actual charge or the MPFS (115% of the lesser of the fee schedule amount and submitted charge) for HCPCS code G0296 only,

-Rural Health Clinics (RHCs) - TOB 71X - based on the all-inclusive rate for HCPCS G0296 only, and

-Federally Qualified Health Centers (FQHCs) – TOB 77X - based on the prospective payment systems (PPS) rate for HCPCS G0296 only.

NOTE: *For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered and performed by eligible Medicare providers for these services that meet the eligibility and coverage requirements of this NCD. See Pub.100-03, Medicare NCD Manual, Chapter 1, Section 210.14, for complete coverage requirements.*

220.3 – Deductible and Coinsurance

(Rev.3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

There is no deductible and no coinsurance for HCPCS codes G0296 and G0297 claim lines.

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

(Rev.3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

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 G0297:

- *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.*

- *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, 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 G0297 because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered:*

  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 G0297 because the claim line was not billed with ICD-9 code V15.82 (ICD-10 Z87.891, personal history of tobacco use/personal history of nicotine dependence):*

  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.3374, Issued: 10-15-15, Effective: 02-05-15, Implementation: 01-04-16)

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

Allow one HCPCS code G0297 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 G0297 claims lines for beneficiaries that are not between the ages of 55 and 77.