CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3901	**Date: November 3, 2017**
	Change Request 10338

SUBJECT: Update to Pub 100-04, Chapter 18 Preventive and Screening Services - Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

I. SUMMARY OF CHANGES: This change request (CR) revises Pub 100-04, Chapter 18, Section 220.4 to include additional diagnosis codes that were added in CR 9540, Transmittal 1658 issued on April 29, 2016.

EFFECTIVE DATE: December 4, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 4, 2017

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/220.4/ Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

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: 3901	Date: November 3, 2017	Change Request: 10338

SUBJECT: Update to Pub 100-04, Chapter 18 Preventive and Screening Services - Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

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I. GENERAL INFORMATION

A. Background: Change Request (CR) 9246 informs Medicare Administrative Contractors (MACs) that Medicare covers lung cancer screening with low-dose computed tomography (LDCT) if all eligibility requirements listed in Publication (Pub.) 100-03, the National Coverage Determinations (NCD) Manual are met effective February 5, 2015.

This CR revises Pub 100-04, Chapter 18, Section 220.4, to include additional diagnosis codes that were implemented in CR 9540 (Business Requirement 9540.8), which shall be included on claims billed for LDCT coverage.

The additional diagnosis codes that were added are:

ICD-9 code: 305.1 (identifying past or current tobacco use, respectively) for dates of service February 5, 2015, through September 30, 2015

ICD-10 codes: F17.210 (Nicotine dependence, cigarettes, uncomplicated), F17.211 (Nicotine dependence, cigarettes, in remission), F17.213 (Nicotine dependence, cigarettes, with withdrawal), F17.218 (Nicotine dependence, cigarettes, with other nicotine-induced disorders), or F17.219 (Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders), effective with dates of service on or after October 1, 2015.

B. Policy: There are no policy changes with this CR.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10338.1	Contractors shall comply with the instructions found in the CMS Internet Only Manual (IOM) Publication 100-04, Chapter 18, Section 220.4 updated with this CR.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr, Wendy.Knarr@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

220.4 – Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
(Rev.3901; Issued: 11-03-17; Effective: 12-04-17; Implementation: 12-04-17)

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.

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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 codes V15.82 or *305.1, identifying past or current tobacco use, respectively, for dates of service February 5, 2015, through September 30, 2015, or ICD-10 codes Z87.891(personal history of tobacco use/personal history of nicotine dependence), F17.210 (Nicotine dependence, cigarettes, uncomplicated), F17.211 (Nicotine dependence, cigarettes, in remission), F17.213 (Nicotine dependence, cigarettes, with withdrawal), F17.218 (Nicotine dependence, cigarettes, with other nicotine-induced disorders), or F17.219 (Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders), effective with dates of service on or after October 1, 2015.*

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.

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