

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3650	Date: November 10, 2016
	Change Request 9841

SUBJECT: Updates to Pub. 100-04, Chapters 8, 13 and 14 to Correct Remittance Advice Messages

I. SUMMARY OF CHANGES: This Change Request revises chapters 8, 13 and 14 of the Medicare Claims Processing Manual to ensure that all remittance advice coding is consistent with nationally standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual.

EFFECTIVE DATE: February 10, 2017

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

IMPLEMENTATION DATE: February 10, 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	8/60.2.4.2/Physician Billing Requirements to the A/B MAC (B)
D	8/60.4.3/Epoetin Alfa (EPO) Supplier Billing Requirements (Method II) on the Form CMS 1500
D	8/60.4.5/ESAs Furnished to Home Patients
D	8/60.4.6/Darbepoetin Alfa (Aranesp) Supplier Billing Requirements (Method II) on the Form CMS-1500 and Electronic Equivalent
R	8/180/Noninvasive Studies for ESRD Patients - Facility and Physician Services
R	13/40.2/Medicare Summary Notices (MSN), Reason Codes, and Remark Codes
R	13/60.3.3/Denial Messages for Noncovered PET Services
D	13/60.3.4/Remittance Advice Message
R	13/60.12/Coverage for PET Scans for Dementia and Neurodegenerative Diseases
R	13/60.16/Billing and Coverage Changes for PET Scans Effective for Services on or After April 3, 2009
R	13/60.17/Billing and Coverage Changes for PET Scans for Cervical Cancer Effective for Services on or After November 10, 2009
R	13/60.18/Billing and Coverage Changes for PET (NaF-18) Scans to Identify Bone Metastasis of Cancer Effective for Claims With Dates of Services on or After February 26, 2010
R	13/60.19/Local Coverage Determination for PET Using New, Proprietary Radiopharmaceuticals for their FDA-Approved Labeled Indications for Oncologic Imaging Only
R	13/140.2 - Denial Messages for Noncovered Bone Mass Measurements
D	13/140.3/Remittance Advice Messages
R	14/10.2/Ambulatory Surgical Center Services on ASC List
R	14/60.1/Applicable Messages for NTIOLs
R	14/60.2/Applicable Messages for ASC 2008 Payment Changes Effective January 1, 2008
R	14/60.3/Applicable ASC Messages for Certain Payment Indicators Effective for Services Performed on or after January 1, 2009

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**

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H		
9841.2	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): Brian Reitz, brian.reitz@cms.hhs.gov, Wil Gehne, wilfried.gehne@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

60.2.4.2 - Physician Billing Requirements to the A/B MAC (B) *(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)*

A. Sodium Ferric Gluconate Complex in Sucrose Injection

Sodium Ferric Gluconate Complex in sucrose injection may be payable for claims with dates of service on or after December 1, 2000 when furnished intravenously, for first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy. Physicians bill and A/B MACs (B) pay for HCPCS code J1756 when submitted with a primary diagnosis for chronic renal failure and a secondary diagnosis for iron deficiency anemia.

These diagnoses are listed below. Use ICD-9-CM or ICD-10-CM as applicable for the service date.

Chronic Renal Failure (Primary Diagnosis)

- ICD-9-CM – 585
- ICD-10-CM – N18.3, N18.4, N18.5, N18.6,

Iron Deficiency Anemia (Secondary Diagnosis)

- ICD-9-CM – 280.0, 280.1, 280.8, or 280.9
- ICD-10-CM – D50.0, D50.1, D50.8, D50.9, D63.1

This benefit is subject to the Part B deductible and coinsurance and should be paid per current Medicare drug payment reimbursement rules. A/B MACs (B) may cover other uses of this drug at their discretion.

B. Iron Sucrose Injection

Iron Sucrose injections are payable for claims with dates of service on or after October 1, 2001, when furnished intravenously, for first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy. Until a specific code for iron sucrose injection is developed, providers must submit HCPCS code J1756, with the appropriate explanation of drug name and dosage entered on the claim. The primary diagnosis code for chronic renal failure and one of the following secondary diagnosis codes for iron deficiency must be entered.

These diagnoses are listed below. Use ICD-9-CM or ICD-10-CM as applicable for the service date.

Chronic Renal Failure (Primary Diagnosis)

- ICD-9-CM - 585
- ICD-10-CM - N18.3, N18.4, N18.5, N18.6,

Iron Deficiency Anemia (Secondary Diagnosis)

- ICD-9-CM – 280.0, 280.1, 280.8, or 280.9
- ICD-10-CM – D50.0, D50.1, D50.8, D50.9, D63.1

Iron sucrose injection is subject to the Part B deductible and coinsurance and should be paid per current Medicare drug payment reimbursement rules. A/B MACs (B) may cover other uses of this drug at their discretion.

C. Messages for Use with Denials

The *contractor shall* deny claims for sodium ferric gluconate complex in sucrose injection or iron sucrose injection due to a missing diagnosis code.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: M76
MSN: 9.2

180 - Noninvasive Studies for ESRD Patients - Facility and Physician Services *(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)*

For Medicare coverage of noninvasive vascular studies, see the Medicare Benefit Policy Manual, Chapter 11.

For dialysis to take place there must be a means of access so that the exchange of waste products may occur. As part of the dialysis treatment, ESRD facilities are responsible for monitoring access, and when occlusions occur, either declot the access or refer the patient for appropriate treatment. Procedures associated with monitoring access involve taking venous pressure, aspirating thrombus, observing elevated recirculation time, reduced urea reduction ratios, or collapsed shunt, etc. All such procedures are covered under the composite rate.

ESRD facilities may not monitor access through noninvasive vascular studies such as duplex and Doppler flow scans and bill separately for these procedures. Noninvasive vascular studies are not covered as a separately billable service if used to monitor a patient's vascular access site.

Medicare pays for the technical component of the procedure in the composite payment rate.

Where there are signs and symptoms of vascular access problems, Doppler flow studies may be used as a means to obtain diagnostic information to permit medical intervention to address the problem. Doppler flow studies may be considered medically necessary in the presence of signs or symptoms of possible failure of the ESRD patient's vascular access site, and when the results are used in determining the clinical course of the treatment for the patient.

The only Current Procedural Terminology (CPT) billing code for noninvasive vascular testing of a hemodialysis access site is 93990. A/B MACs (B) must deny separate billing of the technical component of this code if it is performed on any patient for whom the ESRD composite rate for dialysis is being paid, unless there is appropriate medical indication of the need for a Doppler flow study.

When a dialysis patient exhibits signs and symptoms of compromise to the vascular access site, Doppler flow studies may provide diagnostic information that will determine the appropriate medical intervention. Medicare considers a Doppler flow study medically necessary when the beneficiary's dialysis access site manifests signs or symptoms associated with vascular compromise, and when the results of this test are necessary to determine the clinical course of treatment.

Examples supporting the medical necessity for Doppler flow studies include:

- a. Elevated dynamic venous pressure >200mm HG when measured during dialysis with the blood pump set on a 200cc/min.,
- b. Access recirculation of 12 percent or greater,
- c. An otherwise unexplained urea reduction ration <60 oercebtm abd

- d. An access with a palpable “water hammer” pulse on examination, (which implies venous outflow obstruction).

Unless the documentation is provided supporting the necessity of more than one study, Medicare will limit payment to either a Doppler flow study or an arteriogram (fistulogram, venogram), but not both.

An example of when both studies may be clinically necessary is when a Doppler flow study demonstrates reduced flow (blood flow rate less than 800cc/min or a decreased flow of 25 percent or greater from previous study) and the physician requires an arteriogram to further define the extent of the problem. The patient’s medical record(s) must provide documentation supporting the need for more than one imaging study.

This policy is applicable to claims from ESRD facilities and all other sources, such as independent diagnostic testing facilities, and hospital outpatient departments.

A/B MACs (B) shall develop LMRP for Doppler flow studies if this service meets the criteria listed in the Medicare Program Integrity Manual, Chapter 1. This provides guidance to contractors on the scope, purpose, and meaning of LMRP.

The professional component of the procedure is included in the monthly capitation payment (MCP) (See §140 above.) The professional component should be denied for code 93990 if billed by the MCP physician. Medically necessary services that are included or bundled into the MCP (e.g., test interpretations) are separately payable when furnished by physicians other than the MCP physician.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

Group Code: CO

CARC: 24

RARC: N/A

MSN:16.32

Billing for monitoring of hemodialysis access using CPT codes for noninvasive vascular studies other than 93990 is considered a misrepresentation of the service actually provided and contractors will consider this action for fraud investigation. They will conduct data analysis on a periodic basis for noninvasive diagnostic studies of the extremities (including CPT codes 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971). Contractors should handle aberrant findings under normal program safeguard processes by taking whatever corrective action is deemed necessary.

Medicare Claims Processing Manual

Chapter 13 - Radiology Services and Other Diagnostic Procedures

Table of Contents *(Rev. 3650, 11-10-16)*

60.3.3 – Denial Messages for Noncovered PET Services

140.2 - Denial Messages for Noncovered Bone Mass Measurements

40.2 – Medicare Summary Notices (MSN), Reason Codes, and Remark Codes *(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)*

The A/B MAC denies MRI line items on claims when billed with the appropriate MRI code and a diagnostic code for cardiac pacemaker if modifier KX is not present.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

*Group Code: CO
CARC: 188
RARC: N/A
MSN: 21.8*

The A/B MAC denies MRI line items that do not include all of the following line items:

- An appropriate MRI code,
- If ICD-9-CM is applicable, ICD-9 code V45.02 (automatic implantable cardiac defibrillator) or ICD-9 code V45.01 (cardiac pacemaker),
- ICD-10-CM is applicable, ICD-10 code Z95.810 (automatic implantable cardiac defibrillator) or ICD-10 code Z95.0 (cardiac pacemaker),
- Modifier Q0,
- If ICD-9-CM is applicable, ICD-9 code V70.7 Examination of participant in clinical trial (for institutional claims only) or
- If ICD-10-CM is applicable, ICD-10 code Z00.6 – Examination of participant in clinical trial (for institutional claims only), and
- Condition code 30 (for institutional claims only).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

*Group Code: CO
CARC: 272
RARC: N386
MSN: 21.21*

60.3.3 – Denial Messages for Noncovered PET Services *(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)*

The A/B MAC denies claims for noncovered procedure code, such as 78609.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

*Group Code: CO
CARC: 96
RARC: N386
MSN: 16.10*

60.12 - Coverage for PET Scans for Dementia and Neurodegenerative Diseases *(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)*

Effective for dates of service on or after September 15, 2004, Medicare will cover FDG PET scans for a differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease OR; its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases. Refer to Pub. 100-03, NCD Manual, section [220.6.13](#), for complete coverage conditions and clinical trial requirements and section 60.15 of this manual for claims processing information.

A. A/B MAC (A and B) Billing Requirements for PET Scan Claims for FDG-PET for the Differential Diagnosis of Fronto-temporal Dementia and Alzheimer's Disease:

CPT Code for PET Scans for Dementia and Neurodegenerative Diseases

Contractors shall advise providers to use the appropriate CPT code from section 60.3.1 for dementia and neurodegenerative diseases for services performed on or after January 28, 2005.

Diagnosis Codes for PET Scans for Dementia and Neurodegenerative Diseases

The contractor shall ensure one of the following appropriate diagnosis codes is present on claims for PET Scans for AD:

- If ICD-9-CM is applicable, ICD-9 codes are: 290.0, 290.10 - 290.13, 290.20 - 290, 21, 290.3, 331.0, 331.11, 331.19, 331.2, 331.9, 780.93
- If ICD-10-CM is applicable, ICD-10 codes are: F03.90, F03.90 plus F05, G30.9, G31.01, G31.9, R41.2 or R41.3

Medicare contractors shall deny claims when submitted with an appropriate CPT code from section 60.3.1 and with a diagnosis code other than the range of codes listed above.

Medicare contractors shall instruct providers to issue an Advanced Beneficiary Notice to beneficiaries advising them of potential financial liability prior to delivering the service if one of the appropriate diagnosis codes will not be present on the claim.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

*Group Code: PR (if claim is received with a GA modifier) otherwise CO
CARC: 11
RARC: N/A
MSN: 16.48*

Provider Documentation Required with the PET Scan Claim

Medicare contractors shall inform providers to ensure the conditions mentioned in the NCD Manual, section [220.6.13](#), have been met. The information must also be maintained in the beneficiary's medical record:

- Date of onset of symptoms;
- Diagnosis of clinical syndrome (normal aging, mild cognitive impairment or MCI: mild, moderate, or severe dementia);
- Mini mental status exam (MMSE) or similar test score;
- Presumptive cause (possible, probably, uncertain AD);
- Any neuropsychological testing performed;
- Results of any structural imaging (MRI, CT) performed;
- Relevant laboratory tests (B12, thyroid hormone); and,
- Number and name of prescribed medications.

B. Billing Requirements for Beta Amyloid Positron Emission Tomography (PET) in Dementia and Neurodegenerative Disease:

Effective for claims with dates of service on and after September 27, 2013, Medicare will only allow coverage with evidence development (CED) for Positron Emission Tomography (PET) beta amyloid (also referred to as amyloid-beta (Aβ)) imaging (HCPCS A9586) or (HCPCS **A9599**) (one PET Aβ scan per patient).

NOTE: Please note that effective January 1, 2014 the following code A9599 will be updated in the IOCE and HCPCS update. This code will be contractor priced.

Medicare Summary Notices, Remittance Advice Remark Codes, and Claim Adjustment Reason Codes

Effective for dates of service on or after September 27, 2013, contractors shall **return as unprocessable/return to provider** claims for PET Aβ imaging, through CED during a clinical trial, not containing the following:

- Condition code 30, (A/B MAC (A) only)
- Modifier Q0 and/or modifier Q1 as appropriate
- ICD-9 dx code V70.7/ICD-10 dx code Z00.6 (on either the primary/secondary position)
- A PET HCPCS code (78811 or 78814)
- At least, one Dx code from the table below,

ICD-9 Codes	Corresponding ICD-10 Codes
290.0 Senile dementia, uncomplicated	F03.90 Unspecified dementia without behavioral disturbance
290.10 Presenile dementia, uncomplicated	F03.90 Unspecified dementia without behavioral disturbance
290.11 Presenile dementia with delirium	F03.90 Unspecified dementia without behavioral disturbance
290.12 Presenile dementia with delusional features	F03.90 Unspecified dementia without behavioral disturbance
290.13 Presenile dementia with depressive features	F03.90 Unspecified dementia without behavioral disturbance
290.20 Senile dementia with delusional features	F03.90 Unspecified dementia without behavioral disturbance

ICD-9 Codes	Corresponding ICD-10 Codes
290.21 Senile dementia with depressive features	F03.90 Unspecified dementia without behavioral disturbance
290.3 Senile dementia with delirium	F03.90 Unspecified dementia without behavioral disturbance
290.40 Vascular dementia, uncomplicated	F01.50 Vascular dementia without behavioral disturbance
290.41 Vascular dementia with delirium	F01.51 Vascular dementia with behavioral disturbance
290.42 Vascular dementia with delusions	F01.51 Vascular dementia with behavioral disturbance
290.43 Vascular dementia with depressed mood	F01.51 Vascular dementia with behavioral disturbance
294.10 Dementia in conditions classified elsewhere without behavioral disturbance	F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance
294.11 Dementia in conditions classified elsewhere with behavioral disturbance	F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance
294.20 Dementia, unspecified, without behavioral disturbance	F03.90 Unspecified dementia without behavioral disturbance
294.21 Dementia, unspecified, with behavioral disturbance	F03.91 Unspecified dementia with behavioral disturbance
331.11 Pick's Disease	G31.01 Pick's disease
331.19 Other Frontotemporal dementia	G31.09 Other frontotemporal dementia
331.6 Corticobasal degeneration	G31.85 Corticobasal degeneration
331.82 Dementia with Lewy Bodies	G31.83 Dementia with Lewy bodies
331.83 Mild cognitive impairment, so stated	G31.84 Mild cognitive impairment, so stated
780.93 Memory Loss	R41.1 Anterograde amnesia R41.2 Retrograde amnesia R41.3 Other amnesia (Amnesia NOS, Memory loss NOS)
V70.7 Examination for normal comparison or control in clinical	Z00.6 Encounter for examination for normal comparison and control in clinical research program

and

- A β HCPCS code A9586 or A9599

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 4

RARC: N517, N519

MSN: N/A

Contractors shall line-item **deny** claims for PET Aβ , HCPCS code A9586 or A9599 , where a previous PET Aβ, HCPCS code A9586 or A9599 is paid in history.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR (if claim is received with a GA modifier) otherwise CO

CARC: 149

RARC: N587

MSN: 20.12

60.16 - Billing and Coverage Changes for PET Scans Effective for Services on or After April 3, 2009

(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)

A. Summary of Changes

Effective for services on or after April 3, 2009, Medicare will **not cover** the use of FDG PET imaging to determine **initial treatment strategy** in patients with adenocarcinoma of the prostate.

Medicare will also not cover FDG PET imaging for **subsequent treatment strategy** for tumor types other than breast, cervical, colorectal, esophagus, head and neck (non-CNS/thyroid), lymphoma, melanoma, myeloma, non-small cell lung, and ovarian, unless the FDG PET is provided under the coverage with evidence development (CED) paradigm (billed with modifier -Q0/-Q1, see section 60.15 of this chapter).

Medicare will cover FDG PET imaging **for initial treatment strategy** for myeloma.

Effective for services performed on or after June 11, 2013, Medicare has ended the CED requirement for FDG PET and PET/CT and PET/MRI for all oncologic indications contained in section 220.6.17 of the NCD Manual. Effective for services on or after June 11, 2013, the Q0/Q1 modifier is no longer required.

Beginning with services performed on or after June 11, 2013, contractors shall pay for up to three (3) FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy (modifier PS) after completion of initial anti-cancer therapy (modifier PI) for the exact same cancer diagnosis.

Coverage of any additional FDG PET scans (that is, beyond 3) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-tumor therapy for the same cancer diagnosis will be determined by the A/B MACs (A or B). Claims will include the KX modifier indicating the coverage criteria is met for coverage of four or more FDG PET scans for subsequent treatment strategy for the same cancer diagnosis under this NCD.

A different cancer diagnosis whether submitted with a PI or a PS modifier will begin the count of one initial and three subsequent FDG PET scans not requiring the KX modifier and four or more FDG PET scans for subsequent treatment strategy for the same cancer diagnosis requiring the KX modifier.

NOTE: The presence or absence of an initial treatment strategy claim in a beneficiary's record does not impact the frequency criteria for subsequent treatment strategy claims for the same cancer diagnosis.

NOTE: Providers please refer to the following link for a list of appropriate diagnosis codes, http://cms.gov/medicare/coverage/determinationprocess/downloads/petforsolidtumorsononcologicdxcodesattachment_NCD220_6_17.pdf

For further information regarding the changes in coverage, refer to Pub.100-03, NCD Manual, section 220.6.17.

B. Modifiers for PET Scans

Effective for claims with dates of service on or after April 3, 2009, the following modifiers have been created for use to inform for the **initial treatment strategy** of biopsy-proven or strongly suspected tumors or **subsequent treatment strategy** of cancerous tumors:

PI Positron Emission Tomography (PET) or PET/Computed Tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing.

Short descriptor: PET tumor init tx strat

PS Positron Emission Tomography (PET) or PET/Computed Tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treatment physician determines that the PET study is needed to inform subsequent anti-tumor strategy.

Short descriptor: PS - PET tumor subsq tx strategy

C. Billing for A/B MACs (A and B)

Effective for claims with dates of service on or after April 3, 2009, contractors shall accept FDG PET claims billed to inform **initial treatment strategy** with the following CPT codes **AND** modifier PI: 78608, 78811, 78812, 78813, 78814, 78815, 78816.

Effective for claims with dates of service on or after April 3, 2009, contractors shall accept FDG PET claims with modifier PS for the **subsequent treatment strategy** for solid tumors using a CPT code above **AND** a cancer diagnosis code.

Contractors shall also accept FDG PET claims billed to **inform initial treatment strategy or subsequent treatment strategy** when performed under CED with one of the PET or PET/CT CPT codes above **AND** modifier PI **OR** modifier PS **AND** a cancer diagnosis code **AND** modifier Q0/Q1. Effective for services performed on or after June 11, 2013, the CED requirement has ended and modifier Q0/Q1, along with condition code 30 (institutional claims only), or ICD-9 code V70.7, (both institutional and practitioner claims) are no longer required.

D. Medicare Summary Notices, Remittance Advice Remark Codes, and Claim Adjustment Reason Codes

Effective for dates of service on or after April 3, 2009, contractors shall **return as unprocessable/return to provider** claims that do not include the PI modifier with one of the PET/PET/CT CPT codes listed in subsection C. above when billing for **the initial treatment strategy** for solid tumors in accordance with Pub.100-03, NCD Manual, section 220.6.17.

In addition, contractors shall **return as unprocessable/return to provider** claims that do not include the PS modifier with one of the CPT codes listed in subsection C. above when billing for the **subsequent treatment strategy** for solid tumors in accordance with Pub.100-03, NCD Manual, section 220.6.17.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 4
RARC: MA130
MSN: N/A

Effective for claims with dates of service on or after April 3, 2009, through June 10, 2013, contractors shall **return as unprocessable/return to provider** FDG PET claims billed to **inform initial treatment strategy or subsequent treatment strategy** when performed under CED without one of the PET/PET/CT CPT codes listed in subsection C. above **AND** modifier PI **OR** modifier PS **AND** a cancer diagnosis code **AND** modifier Q0/Q1.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 4
RARC: MA130
MSN: N/A

Effective April 3, 2009, contractors shall **deny** claims with ICD-9/ICD-10 diagnosis code 185/C61 for FDG PET imaging for the **initial treatment strategy** of patients with adenocarcinoma of the prostate.

For dates of service prior to June 11, 2013, contractors shall also **deny** claims for FDG PET imaging for **subsequent treatment strategy** for tumor types other than breast, cervical, colorectal, esophagus, head and neck (non-CNS/thyroid), lymphoma, melanoma, myeloma, non-small cell lung, and ovarian, unless the FDG PET is provided under CED (submitted with the Q0/Q1 modifier) and use the following messages:

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR (if claim is received with a GA modifier) otherwise CO
CARC: 50
RARC: N/A
MSN: 15.4

Effective for dates of service on or after June 11, 2013, contractors shall use the following messages when denying claims in excess of **three** for PET FDG scans for subsequent treatment strategy when the KX modifier is not included, identified by CPT codes 78608, 78811, 78812, 78813, 78814, 78815, or 78816, modifier PS, HCPCS A9552, and the same cancer diagnosis code.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR (if claim is received with a GA modifier) otherwise CO
CARC: 96
RARC: N435
MSN: 23.17

60.17 – Billing and Coverage Changes for PET Scans for Cervical Cancer Effective for Services on or After November 10, 2009
(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)

A. Billing Changes for A/B MACs (A and B)

Effective for claims with dates of service on or after November 10, 2009, contractors shall accept FDG PET oncologic claims billed to inform initial treatment strategy; specifically for staging in beneficiaries who have biopsy-proven cervical cancer when the beneficiary's treating physician determines the FDG PET study is needed to determine the location and/or extent of the tumor as specified in Pub. 100-03, section 220.6.17.

EXCEPTION: CMS continues to non-cover FDG PET for initial diagnosis of cervical cancer related to initial treatment strategy.

NOTE: Effective for claims with dates of service on and after November 10, 2009, the –Q0 modifier is no longer necessary for FDG PET for cervical cancer.

B. Medicare Summary Notices, Remittance Advice Remark Codes, and Claim

Adjustment Reason Codes

Additionally, contractors shall return as unprocessable /return to provider for FDG PET for cervical cancer for initial treatment strategy billed without the following: one of the PET/PET/ CT CPT codes listed in 60.16 C above **AND** modifier PI **AND** a cervical cancer diagnosis code.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 4

RARC: MA130

MSN: N/A

60.18 – Billing and Coverage Changes for PET (NaF-18) Scans to Identify Bone Metastasis of Cancer Effective for Claims With Dates of Services on or After February 26, 2010

(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)

A. Billing Changes for A/B MACs (A and B)

Effective for claims with dates of service on and after February 26, 2010, contractors shall pay for NaF-18 PET oncologic claims to inform of initial treatment strategy (PI) or subsequent treatment strategy (PS) for suspected or biopsy proven bone metastasis **ONLY** in the context of a clinical study and as specified in Pub. 100-03, section 220.6. All other claims for NaF-18 PET oncology claims remain non-covered.

B. Medicare Summary Notices, Remittance Advice Remark Codes, and Claim Adjustment Reason Codes

Effective for claims with dates of service on or after February 26, 2010, contractors shall return as unprocessable NaF-18 PET oncologic claims billed with **modifier TC or globally (for A/B MACs (A) modifier TC or globally does not apply)** and HCPCS A9580 to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis that do not include ALL of the following:

- PI or PS modifier AND
- PET or PET/CT CPT code (78811, 78812, 78813, 78814, 78815, 78816) AND
- Cancer diagnosis code AND

- Q0 modifier - Investigational clinical service provided in a clinical research study, are present on the claim.

NOTE: For institutional claims, continue to include ICD-9 diagnosis code V70.7 or ICD-10 diagnosis code Z00.6 and condition code 30 to denote a clinical study.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two

*Group Code: CO
CARC: 4
RARC: MA130
MSN: N/A*

Effective for claims with dates of service on or after February 26, 2010, contractors shall accept PET oncologic claims billed with **modifier 26** and modifier KX to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis that include the following:

- PI or PS modifier AND
- PET or PET/CT CPT code (78811, 78812, 78813, 78814, 78815, 78816) AND
- Cancer diagnosis code AND
- Q0 modifier - Investigational clinical service provided in a clinical research study, are present on the claim.

NOTE: If modifier KX is present on the professional component service, Contractors shall process the service as PET NaF-18 rather than PET with FDG.

Contractors shall also return as unprocessable NaF-18 PET oncologic professional component claims (i.e., claims billed with **modifiers 26** and KX) to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis billed with HCPCS A9580.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

*Group Code: CO
CARC: 4
RARC: MA130
MSN: N/A*

60.19 – Local Coverage Determination for PET Using New, Proprietary Radiopharmaceuticals for their FDA-Approved Labeled Indications for Oncologic Imaging Only

(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)

Effective for dates of service on or after March 7, 2013, local Medicare Administrative Contractors (MACs) may determine coverage within their respective jurisdictions for positron emission tomography (PET) using radiopharmaceuticals for their Food and Drug Administration (FDA) approved labeled indications for oncologic imaging. When the local MAC determines that a claim is noncovered, the *claim is denied*:

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

*Group Code: PR (if claim is received with a GA modifier) otherwise CO
CARC: 167
RARC: N/A
MSN: 15.4*

140.2 - Denial Messages for Noncovered Bone Mass Measurements
(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under the conditions described in 140.1. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

*Group Code: PR (if claim is received with a GA modifier) otherwise CO
CARC: 50
RARC: Alert M38 (if ABN was issued) or M27 (if ABN was not issued)
MSN: 16.10 and 36.1 (if ABN was issued) or 36.2 (if ABN was not issued)*

NOTE: A/B MACs (A) are not to include MSN 16.10.

10.2 - Ambulatory Surgical Center Services on ASC List

(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)

Covered ASC services are those surgical procedures that are identified by CMS on a listing that is updated at least annually. Some surgical procedures covered by Medicare are not on the ASC list of covered surgical procedures. For surgical procedures not covered in ASCs, the related professional services may be billed by the rendering provider as Part B services and the beneficiary is liable for the facility charges, which are non-covered by Medicare.

Under the ASC payment system, Medicare makes facility payments to ASCs only for the specific ASC covered surgical procedures on the ASC list of covered surgical procedures. In addition, Medicare makes separate payment to ASCs for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. All other non-ASC services, such as physician services and prosthetic devices may be covered and separately billable under other provisions of Medicare Part B. The Medicare definition of covered ASC facility services for a covered surgical procedure includes services that would be covered if furnished on an inpatient or outpatient basis in connection with a covered surgical procedure. This includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to patients needing surgical procedures. It includes all services and procedures provided in connection with covered surgical procedures furnished by nurses, technical personnel and others involved in patient care. These do not include physician services or medical and other health services for which payment may be made under other Medicare provisions (e.g., services of an independent laboratory located on the same site as the ASC, anesthetist professional services, non-implantable DME).

ASC services for which payment is included in the ASC payment for a covered surgical procedure under 42CFR416.65 include, but are not limited to-

(a) Included facility services:

- (1) Nursing, technician, and related services;
- (2) Use of the facility where the surgical procedures are performed;
- (3) Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;
- (4) Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);
- (5) Medical and surgical supplies not on pass-through status under Subpart G of Part 419 of 42 CFR;
- (6) Equipment;
- (7) Surgical dressings;
- (8) Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR;
- (9) Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR;
- (10) Splints and casts and related devices;

(11) Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;

(12) Administrative, recordkeeping and housekeeping items and services;

(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(14) Supervision of the services of an anesthetist by the operating surgeon.

Under the revised ASC payment system, the above items and services fall within the scope of ASC facility services, and payment for them is packaged into the ASC payment for the covered surgical procedure. ASCs must incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Because contractors pay the lesser of 80 percent of actual charges or the ASC payment rate for the separately payable procedure, and because this comparison is made at the claim line-item level, facilities may not be paid appropriately if they unbundle charges and report those charges for packaged codes as separate line-item charges.

There is a payment adjustment for insertion of an IOL approved as belonging to a class of NTIOLs, for the 5-year period of time established for that class, as set forth at 42CFR416.200.

Covered ancillary items and services that are integral to a covered surgical procedure, as defined in 42CFR416.61, and for which separate payment to the ASC is allowed include:

(b) Covered ancillary services

(1) Brachytherapy sources;

(2) Certain implantable items that have pass-through status under the OPPS;

(3) Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue;

(4) Certain drugs and biologicals for which separate payment is allowed under the OPPS;

(5) Certain radiology services for which separate payment is allowed under the OPPS.

NOTE: Effective for dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, contractors must ensure that either:

- ordering physician name and NPI or
- referring physician name and NPI

are present on electronic or paper claims.

If this information is missing, contractors shall return as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 16

RARC: N264, N265, N285 or N286 as appropriate

MSN: N/A

Definitions of ASC Facility Services:

Nursing Services, Services of Technical Personnel, and Other Related Services

These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the ASC. In addition to the nursing staff, this category includes orderlies, technical personnel, and others involved in patient care.

Use by the Patient of the ASC Facilities

This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

Drugs, Biologicals, Surgical Dressings, Supplies, Splints, Casts, Appliances, and Equipment

This category includes all supplies and equipment commonly furnished by the ASC in connection with surgical procedures. See the following paragraphs for certain exceptions. Drugs and biologicals are limited to those which cannot be self-administered. See the Medicare Benefit Policy Manual, Chapter 15, §50.2, for a description of how to determine whether drugs can be self-administered.

Under Part B, coverage for surgical dressings is limited to primary dressings, i.e., therapeutic and protective coverings applied directly to lesions on the skin or on openings to the skin required as the result of surgical procedures. (Items such as Ace bandages, elastic stockings and support hose, Spence boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets and pressure garments for the arms and hands are used as secondary coverings and therefore are not covered as surgical dressings.) Although surgical dressings usually are covered as "incident to" a physician's service in a physician's office setting, in the ASC setting, such dressings are included in the facility's services.

However, surgical dressings may be reapplied later by others, including the patient or a member of his family. When surgical dressings are obtained by the patient on a physician's order from a supplier, e.g., a drugstore, the surgical dressing is covered under Part B. The same policy applies in the case of dressings obtained by the patient on a physician's order following surgery in an ASC; the dressings are covered and paid as a Part B service by the DME MAC.

Similarly, "other supplies, splints, and casts" include only those furnished by the ASC at the time of the surgery. Additional covered supplies and materials furnished later are generally furnished as "incident to" a physician's service, not as an ASC facility service. The term "supplies" includes those required for both the patient and ASC personnel, e.g., gowns, masks, drapes, hoses, and scalpels, whether disposable or reusable. Payment for these is included in the rate for the surgical procedure.

Beginning January 1, 2008, the ASC facility payment for a surgical procedure includes payment for drugs and biologicals that are not usually self-administered and that are considered to be packaged into the payment for the surgical procedure under the OPPS. Also, beginning January 1, 2008, Medicare makes separate payment to ASCs for drugs and biologicals that are furnished integral to an ASC covered surgical procedure and that are separately payable under the OPPS.

Diagnostic or Therapeutic Items and Services

These are items and services furnished by ASC staff in connection with covered surgical procedures. Many ASCs perform diagnostic tests prior to surgery that are generally included in the facility charges, such as urinalysis, blood hemoglobin, hematocrit levels, etc. To the extent that such simple tests are included in the ASC facility charges, they are considered facility services. However, under the Medicare program, diagnostic tests are not covered in laboratories independent of a physician's office, rural health clinic, or

hospital unless the laboratories meet the regulatory requirements for the conditions for coverage of services of independent laboratories. (See 42CFR416.49) Therefore, diagnostic tests performed by the ASC other than those generally included in the facility's charge are not covered under Part B and are not to be billed as diagnostic tests. If the ASC has its laboratory certified, the laboratory itself may bill for the tests performed.

The ASC may make arrangements with an independent laboratory or other laboratory, such as a hospital laboratory, to perform diagnostic tests it requires prior to surgery. In general, however, the necessary laboratory tests are done outside the ASC prior to scheduling of surgery, since the test results often determine whether the beneficiary should have the surgery done on an outpatient basis in the first place.

Administrative, Recordkeeping and Housekeeping Items and Services

These include the general administrative functions necessary to run the facility e.g., scheduling, cleaning, utilities, and rent.

Blood, Blood Plasma, Platelets, etc., Except Those to Which Blood Deductible Applies

While covered procedures are not expected to result in extensive loss of blood, in some cases, blood or blood products are required. Usually the blood deductible results in no expenses for blood or blood products being included under this provision. However, where there is a need for blood or blood products beyond the deductible, they are considered ASC facility services and no separate charge is permitted to the beneficiary or the program.

Materials for Anesthesia

These include the anesthetic agents that are not paid separately under the OPSP, and any materials, whether disposable or re-usable, necessary for its administration.

Intraocular Lenses (IOLs) and New Technology IOLs (NTIOLs)

The ASC facility services include IOLs (effective for services furnished on or after March 12, 1990), and NTIOLs (effective for services furnished on or after May 18, 2000), approved by the Food and Drug Administration (FDA) for insertion during or subsequent to cataract surgery.

FDA has classified IOLs into the following categories, any of which are included:

1. Anterior chamber angle fixation lenses;
2. Iris fixation lenses;
3. Irido-capsular fixation lenses; and
4. Posterior chamber lenses.
5. NTIOL Category 1 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000). Note: This category expired May 18, 2005
6. NTIOL Category 2 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000). Note: This category expired May 18, 2005
7. NTIOL Category 3 (as defined in Federal Register Notice, 71 FR 4586, dated January 27, 2006): This category will expire on February 26, 2011.

Note that while generally no separate charges for intraocular lenses (IOLs) are allowed, approved NTIOLS may be billed separately and an adjustment to the facility payment will be made for those lenses that are eligible. (See [§40.3](#).)

60.1 - Applicable Messages for NTIOLS

(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)

Contractors shall return as unprocessable any claims for NTIOLS containing Q1003 alone or with a code other than one of the procedure codes listed in 40.3.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 16

RARC: M67

MSN: N/A

Contractors shall deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC.

The contractor shall use the following remittance advice messages and associated codes when denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 58

RARC: N/A

MSN: 16.2

Contractors shall deny payment for Q1003 if billed by an entity other than a Medicare-approved ASC.

The contractor shall use the following remittance advice messages and associated codes when denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 170

RARC: N/A

MSN: 33.1

Contractors shall deny payment for Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 27

RARC: N/A

MSN: 21.11

A/B MACs (B) shall deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC.

The contractor shall use the following remittance advice messages and associated codes when denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 58

RARC: N/A

MSN: 16.2

60.2 - Applicable Messages for ASC 2008 Payment Changes Effective January 1, 2008
(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)

Contractors shall deny services not included on the ASC facility payment files (ASCFS and ASC DRUG files) when billed by ASCs (specialty 49).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 8

RARC: N95

MSN: 26.4

If there is no approved ASC surgical procedure on the same date for the billing ASC in history, contractors shall return pass-through device claims/line items, brachytherapy claims/line items, drug code (including C9399) claims/line items, and any other ancillary service claims/line items such as radiology procedure claim/line items on the ASCFS list or ASCDRUG list as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 16

RARC: M51

MSN: N/A

Contractors shall deny the technical component for all ancillary services on the ASCFS list billed by specialties other than 49 provided in an ASC setting (POS 24).

The contractor shall use the following remittance advice messages and associated codes when denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 171

*RARC: N/A
MSN: 16.2*

Contractors shall **deny globally billed** ancillary services on the ASCFS list **if** billed by specialties other than 49 provided in an ASC setting (POS 24).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

*Group Code: CO
CARC: 4
RARC: N/A
MSN: 16.2*

Contractors shall deny separately billed implantable devices.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

*Group Code: CO
CARC: 97
RARC: M97
MSN: 16.32*

If there is a related, approved surgical procedure for the billing ASC for the same date of service, also include the following MSN message: 16.8.

60.3 – Applicable ASC Messages for Certain Payment Indicators Effective for Services Performed on or after January 1, 2009

(Rev. 3650, Issued: 11-10-16, Effective: 02-10-17, Implementation: 02-10-17)

Contractors shall deny services for HCPCS with payment indicators **C5** (Inpatient surgical procedure under the OPPS; no payment made.), **M6** (No payment made; paid under another fee schedule), **U5** (Surgical unlisted service excluded from ASC payment. No payment made.), or **X5** (Unsafe surgical procedure in ASC. No payment made).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

*Group Code: CO
CARC: 5
RARC: N/A
MSN: 16.32*

Contractors shall deny services for CPT codes with payment indicators **E5** (Surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made), or **Y5** (Non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR

CARC: 96

RARC: N425

MSN: 16.10

NOTE: Contractors shall assign beneficiary liability for facility charges HCPCS codes billed with ASC payment indicators **C5, E5, U5** and **X5**.

Contractors return as unprocessable services for HCPCS with payment indicator **D5** (Deleted/discontinued code; no payment made).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 181

RARC: N56

MSN: N/A

Contractors shall deny services for HCPCS with payment indicators **L1** (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made), **NI** (Packaged service/item; no separate payment made) or **S1** (Service not surgical in nature; and not a radiology service payable under the OPSS, drug/biological, or brachytherapy source. Packaged item/service; no separate payment made).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

Group Code: CO

CARC: 97

RARC: N390

MSN: 16.32

Contractors shall return as unprocessable services for HCPCS with payment indicators **B5** (Alternative code may be available; no payment made).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 16

RARC: M51

MSN: N/A