CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1713	**Date: September 1, 2016**
	Change Request 9719

Transmittal 1698, dated August 5, 2016, is being rescinded and replaced by Transmittal 1713 dated September 1, 2016, to modify the effective date and make changes to the Background section. All other information remains the same.

SUBJECT: Editing Update for Screening for Sexually Transmitted Infections

I. SUMMARY OF CHANGES: Due to existing editing created in Change Request (CR) 7610, 072X type of bill (TOB) claims containing Healthcare Common Procedure Coding System (HCPCS) codes for Sexually Transmitted Infections (STIs) and diagnosis code V74.5 or V73.89 are incorrectly being denied in full. Editing should have been written as line level denial rather than claim level denial. In addition, editing created in CR8197 contains additional diagnosis codes that should have not been included in the edits. This CR provides instructions for edits to be modified to deny line items rather than claim level denials. In addition, this CR revises diagnosis code requirements for STIs claims.

EFFECTIVE DATE: October 1, 2015 - For claims with dates of service on or after October 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 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
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1713	Date: September 1, 2016	Change Request: 9719

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SUBJECT: Editing Update for Screening for Sexually Transmitted Infections

EFFECTIVE DATE: October 1, 2015 - For claims with dates of service on or after October 1, 2015
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I. GENERAL INFORMATION

A. Background: Change Request (CR) 7610, Transmittal 2476, provided billing instructions for Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling to Prevent STIs. It has been brought to our attention that 072X type of bill (TOB) claims containing STIs codes and diagnosis code V74.5 or V73.89, with dates of service on or after October 1, 2015 are incorrectly being denied. Per CR7610, current editing would deny a claim for STIs services submitted with diagnosis code V74.5 or V73.89 on a TOB other than 13X, 14X, or 85X (without revenue code 096X, 097X, or 098X). Logic for these reason codes should have been written as line level denials rather than claim denials if the appropriate diagnosis code is not reported. In addition, editing created in CR8197 International Classification of Diseases (ICD)-10 Conversion from ICD-9 and Related Code Infrastructure of the Medicare Shared Systems as they Relate to the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, is incorrectly denying line items on 072X claims for STIs. Reason codes created in CR8197 contain additional diagnosis codes that should have not been included.

This CR provides instructions for edits to be modified to deny line items without the appropriate diagnosis code on STIs claims. In addition, this CR revises diagnosis code requirements for STIs claims.

NOTE: See Pub. 100-03, NCD Manual, section 210.10, and Pub. 100-04, CPM, section 18, chapter 170.

B. Policy: No change in Policy. CMS is modifying existing editing to ensure correct payment for claims related to STIs.

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	
9719.1	Contractors shall modify existing editing to deny line items on claims for STIs (HCPCS 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800, 87590, 87591, 87850, 86592, 86593, 86780, 87340, or					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	87341) containing ICD-9 code V74.5 or V73.89 (for claims with dates of service before October 1, 2015) and ICD-10 code Z11.3 or Z11.59 (with dates of service on or after October 1, 2015) when submitted on a TOB other than 13X, 14X, or 85X (without revenue code 096X, 097X, or 098X).									
9719.1.1	Contractors shall deny line items on claims for STIs screening services listed in 9719.1 containing ICD-9 code V74.5 or V73.89 (for claims with dates of service before October 1, 2015) and ICD-10 code Z11.3 or Z11.59 (with dates of service on or after October 1, 2015) when submitted on a TOB other than 13X, 14X, and 85X (without revenue code 096X, 097X, or 098X) using the following messages: CARC170: “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 PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file). Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9719.2	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				

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:
9719.1	Reason Codes 39970 and 39971 created in CR7610 shall be deleted.
9719.1	Reason Codes 59170 and 59171 created in CR8197 are being revised by removing the following ICD-10 codes: O0990, O0991, O0992, O0993, Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, Z72.89, Z72.51, Z72.52, and Z72.53. In addition, reason codes 59170 and 59171 shall be re-activated upon implementation of this change request.

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

V. CONTACTS

Pre-Implementation Contact(s): Bill Ruiz, 410-786-9283 or william.ruiz@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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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