DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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- "PECOS for Provider and Supplier Organizations", Fact Sheet, ICN 903767, Downloadable only

MLN Matters® Number: MM9250 | **Related Change Request (CR) #: CR 9250**

Related CR Release Date: November 6, 2015 | **Effective Date: January 1, 2016**

Related CR Transmittal #: R3402CP | **Implementation Date: January 4, 2016**

Payment Reduction for Computed Tomography (CT) Diagnostic Imaging Services

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims for Computed Tomography (CT) diagnostic imaging services to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs).

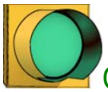
Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is creating the modifier "CT" (Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard). Beginning in 2016, claims for CT scans described by related CPT codes that are furnished on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier "CT" that will result in the applicable payment reduction.

CAUTION – What You Need to Know

Change Request (CR) 9250 informs providers that effective January 1, 2016, a payment reduction of 5 percent applies to CT services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. The payment reduction increases to 15 percent in 2017 and subsequent years.



GO – What You Need to Do

Make sure that your billing staffs are aware of the NEMA standards and the payment reductions related to CT services furnished on equipment inconsistent with the CT equipment standard.

Background

Section 218(a) of the Protecting Access to Medicare Act of 2014 (PAMA) is titled, "Quality Incentives to Promote Patient Safety and Public Health in Computed Tomography Diagnostic Imaging." It amends the Social Security Act (SSA) by reducing payment for the technical component (and the technical component of the global fee) of the Physician Fee Schedule service (5 percent in 2016 and 15 percent in 2017 and subsequent years) for CT services identified by the following CPT codes:

- 70450-70498;
- 71250-71275;
- 72125-72133;
- 72191-72194;
- 73200-73206;
- 73700-73706;
- 74150-74178;
- 74261-74263; and
- 75571-75574.

This applies when the services identified by these codes are furnished using equipment that does not meet each of the attributes of the NEMA Standard XR-29-2013, entitled, "Standard Attributes on CT Equipment Related to Dose Optimization and Management."

The statutory provision requires that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable CT service was furnished that was not consistent with the NEMA CT equipment standard, and that such information may be included on a claim and may be a modifier. The statutory provision also provides that such information shall be verified, as appropriate, as part of the periodic accreditation of suppliers under SSA Section 1834(e) and hospitals under SSA Section 1865(a). Any reduced expenditures resulting form this provision are not budget neutral.

To implement this provision, CMS will create modifier "CT." Beginning in 2016, claims for CT scans described by above-listed CPT codes (and by successor codes) that are furnished

on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier "CT" that will result in the applicable payment reduction.

Beginning January 1, 2016, a payment reduction of 5 percent applies to the technical component (and the technical component of the global fee) for CT services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. This payment reduction becomes 15 percent for 2017 and succeeding years.

When such payment reductions are made, MACs will supply:

- Claim Adjustment Reason Code 237 – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
- Remittance Advice Remark Code N759 – Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013; and
- Group Code: CO (contractual obligation).

Additional Information

The official instruction, CR 9250 issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3402CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

Each Office Visit is an Opportunity to Recommend Influenza Vaccination.
Protect your patients, your staff, and yourself. Medicare Part B covers one influenza vaccination and its administration each influenza season for Medicare beneficiaries. If medically necessary, Medicare may cover additional seasonal influenza vaccinations.

- **Preventive Services** Educational Tool
- **Influenza Vaccine Payment Allowances** MLN Matters Article
- **Influenza Resources for Health Care Professionals** MLN Matters Article
- **CDC Influenza** website