CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 776	**Date: September 24, 2010**
	Change Request 7140

SUBJECT: Clarification on the Effective Date on the Procedure Status Indicator for Common Procedural Terminology (CPT) Code 80101

I. SUMMARY OF CHANGES: This Change Request is to clarify that the effective date for the change of the Procedure Status indicator to I for CPT codes 80101 and 80101QW has been set to January 1, 2010 to maintain consistency for all claims. For claims with DOS on or after January 1, 2010, clinical laboratories shall submit claims with the new test HCPCS code G0431 or G0431QW.

EFFECTIVE DATE: October 26, 2010
IMPLEMENTATION DATE: October 26, 2010

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	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 776	Date: September 24, 2010	Change Request: 7140

SUBJECT: Clarification on the Effective Date on the Procedure Status Indicator for Common Procedural Terminology (CPT) Code 80101

Effective Date: October 26, 2010

Implementation Date: October 26, 2010

I. GENERAL INFORMATION

A. Background: The Center for Medicare and Medicaid Services (CMS) has been receiving inquiries on when the Medicare Procedure Status indicator should be changed to "I" (Not valid for Medicare purposes, Medicare recognizes another code) for CPT 80101 (Drug Screen, Qualitative; Single Drug Class Method). There has been some confusion regarding the compliance between CR 6852, Transmittal 653 issued on March 19, 2010 which changed the indicator effective April 1, 2010 and CR 6909, Transmittal 1957 issued on April 28, 2010 which changed the indicator effective date to July 1, 2010 as well as a third source which is the Clinical Laboratory Fee Schedule (CLFS) file that is utilized by the Medicare contractors changed the indicator effective date to January 1, 2010. This Change Request is to clarify that the effective date for the change of the Procedure Status indicator to "I" for CPT code 80101 has been set to January 1, 2010 to maintain consistency for all claims.

This CR supercedes all previous CMS transmittals concerning the indicator change for CPT code 80101.

B. Policy For claims with Date of Service (DOS) on or after January 1, 2010, CPT codes 80101 and 80101QW are no longer valid on the CLFS. Beginning January 1, 2010, the new test code G0431, Drug Screen, Qualitative; Single Drug Class Method, shall be utilized by those clinical laboratories that do not require a Clinical Laboratory Improvement Act (CLIA) certificate of waiver. Also for claims with DOS on or after January 1, 2010, those clinical laboratories that do require a CLIA certificate of waiver shall utilize the new test code G0431QW.

Claims that were filed and denied for the period January 1, 2010 through June 30, 2010 with CPT code 80101 or 80101QW should be resubmitted with the Health Care Procedure Code (HCPCs) Code G0431 or G0431QW.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		MAC	MAC		RIER	I	FISS	MCS	VMS	CWF	
7140.1	Contractors shall educate their providers to identify claims that were denied during the period of January 1, 2010 through June 30, 2010 as a result of CPT 80101 or 80101QW and resubmit these claims with HCPCs code G0431 or G0431QW.	X		X	X						
7140.2	Contractors shall educate providers who were paid during the period of January 1, 2010 through June 30, 2010 using CPT code 80101 or 80101QW code not to resubmit these claims using CPT code G0431 or G0431QW.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7140.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your 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	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: JSM-10360

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr at Wendy.Knarr@cms.hhs.gov or call Relay at 711 and have relay agent call Wendy at 410-786-0843.

Post-Implementation Contact(s): Your appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.