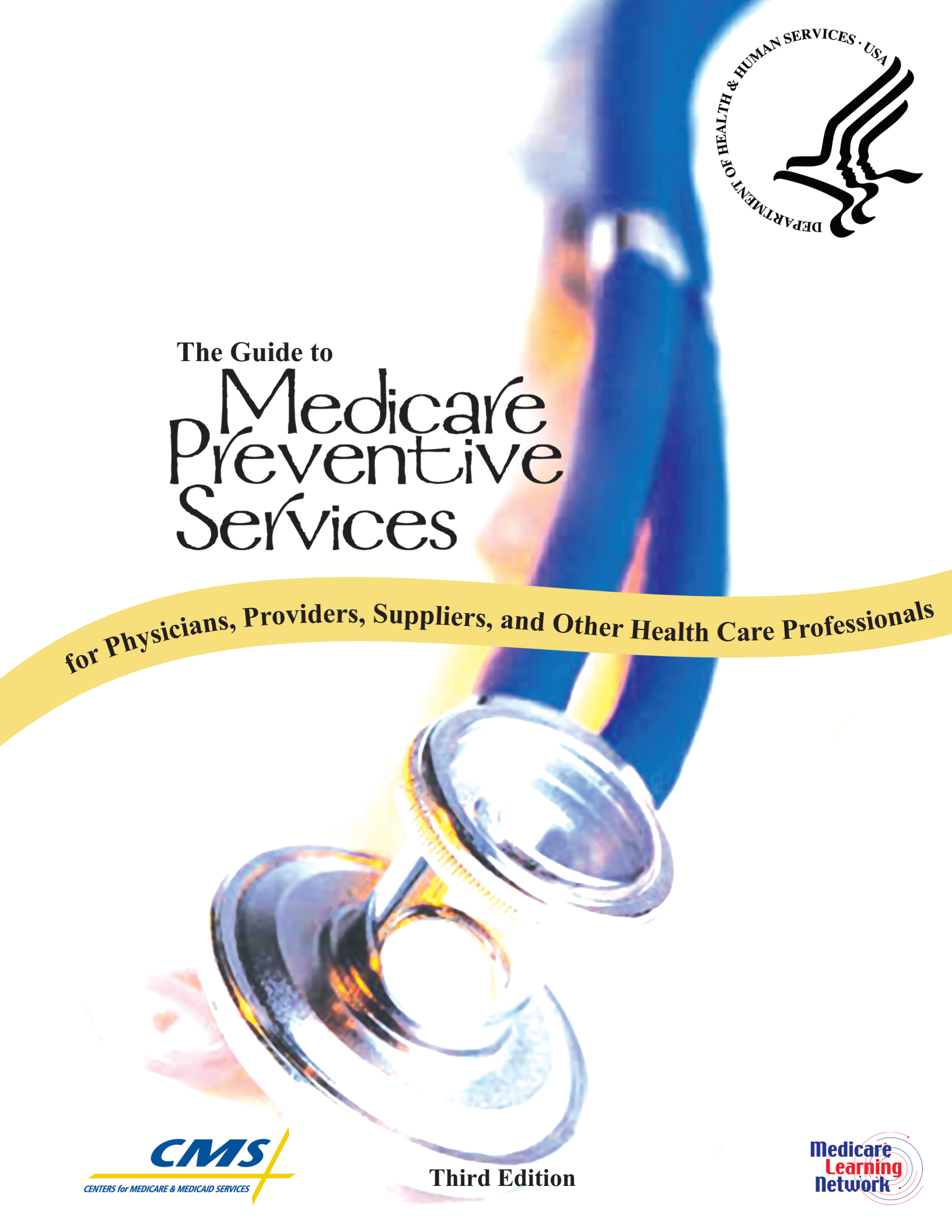

The Guide to Medicare Preventive Services

for Physicians, Providers, Suppliers, and Other Health Care Professionals

Third Edition

CMS
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Medicare Learning Network

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Third Edition
July 2009

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The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

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Table of Contents

The information contained in this publication was current at the time of its development. We encourage users of this publication to review statutes, regulations, and other interpretive materials for the most current information.

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Preface

Welcome to the third edition of The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals. With the release of the third edition of this guide, the Centers for Medicare & Medicaid Services (CMS) is continuing its initiative to educate the provider community and Medicare beneficiaries about the preventive benefits covered by Medicare.

An important part of this initiative includes motivating Medicare beneficiaries to help maintain a healthy lifestyle by making the most of Medicare-covered preventive services. As a Medicare provider, you can encourage your patients to take advantage of preventive services and screenings for which they may be eligible.

Medicare pays for a full range of preventive services and screenings including diabetes, cardiovascular, prostate, and colorectal screenings, among others. These screenings can help people with Medicare stay healthy and detect conditions like cancer, diabetes, and cardiovascular disease early when treatment works best.

CMS recognizes the crucial role that health care providers play in promoting, providing, and educating Medicare beneficiaries about potentially life-saving preventive services and screenings. While Medicare pays for many preventive benefits, many Medicare beneficiaries don't fully realize that using preventive services and screenings can help them live longer, better, healthier lives. As a health care professional, you can help your Medicare patients understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life.

CMS hopes that you will join with us by educating your patients about their risk for disease, the importance of preventive health care and early detection, and the preventive services covered by Medicare that are right for them. Research shows that a physician's recommendation is the most important factor in increasing the use of preventive services and screenings. The information found in this guide can help you communicate with your patients about Medicare-covered preventive benefits, as well as assist you in correctly billing for these services.

CMS has prepared The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals for the health care community as part of our comprehensive national provider education program to inform the fee-for-service health care community about the preventive services and screenings covered by Medicare.

This publication includes coverage, coding, billing, and reimbursement information for each of the preventive benefits covered by Medicare:

- Initial Preventive Physical Examination (IPPE) - the "Welcome to Medicare Physical Exam" or the "Welcome to Medicare Visit"
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
- Cardiovascular Screening Blood Tests
- Diabetes Screening Tests, Supplies, Self-Management Training, Medical Nutrition Therapy, and Other Medicare-Covered Services for People with Diabetes
- Screening Mammography
- Screening Pap Test
- Screening Pelvic Examination

- Colorectal Cancer Screening
- Prostate Cancer Screening
- Influenza Virus, Pneumococcal, and Hepatitis B Vaccinations
- Bone Mass Measurements
- Glaucoma Screening
- Smoking and Tobacco-Use Cessation Counseling Services

An extensive listing of prevention-related resources and websites that health care professionals and beneficiaries may find useful is also included in this guide.

Additional Educational Resources

In addition to this publication, CMS has created a variety of complementary preventive services related resources, including articles, web-based training courses, brochures, and quick reference information charts. We have developed these educational resources to give you and your staff the information you need to assist you in recommending the Medicare-covered preventive services and screenings that are right for your patients and to provide the information you need to effectively bill Medicare for services you furnish. You can order these products, free of charge, from the Medicare Learning Network (MLN) by visiting http://www.cms.hhs.gov/MLNProducts on the CMS website and clicking on the Product Ordering Page in the related links section.

For more preventive services product information, please visit the MLN Preventive Services Educational Products web page located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS website.

We hope that you will find the third edition of The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals and all of the other preventive services educational resources to be useful tools that support you and your staff in the delivery of quality preventive health care to people with Medicare. Thank you for partnering with CMS as we strive to increase awareness of preventive health care and educate health care professionals and beneficiaries about preventive benefits covered by Medicare.

Initial Preventive Physical Examination

Overview

Through legislation passed over the past 25 years, Congress has expanded the number of preventive and screening services available to beneficiaries under the Medicare Part B Program. Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 added coverage of a one-time Initial Preventive Physical Examination (IPPE), also referred to as the "Welcome to Medicare" physical exam or visit. The goals of this benefit are health promotion and disease detection and include education, counseling, and referral for other screening and preventive services also covered under Medicare Part B.

NEW for 2009

Section 101(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided for improvements to the IPPE benefit, including:

- The addition of measurement of body mass index
- End-of-life-planning (upon an individual's consent)
- Extension of the coverage period from 6 months to 12 months
- Waiver of the Medicare Part B deductible for an IPPE visit performed on or after January 1, 2009
- Removal of the mandatory requirement of the screening electrocardiogram (EKG). The screening EKG is optional and is permitted as a one-time screening service as a result of a referral resulting from the IPPE visit.

Important Reminders About the IPPE:

1. The IPPE is a unique benefit available only for beneficiaries new to the Medicare Program and must be received within the first 12 months of the effective date of their Medicare Part B coverage.
2. This exam is a preventive physical exam and not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare Part B does not provide coverage for routine physical exams.

The IPPE is a preventive evaluation and management (E/M) service that includes all of the following components:

1. A review of an individual's medical and social history with attention to modifiable risk factors for disease detection.
2. A review of an individual's potential (risk factors) for depression or other mood disorders.
3. A review of the individual's functional ability and level of safety.
4. An examination to include an individual's height, weight, blood pressure measurement, visual acuity screen, measurement of body mass index (required service effective January 1, 2009), and other factors as deemed appropriate by the examining physician or qualified non-physician practitioner.
5. End-of-life planning, effective for dates of service on or after January 1, 2009 (upon an individual's consent).
6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five components.

7. Education, counseling, and referral for other preventive services (including a brief written plan such as a checklist provided to the individual for obtaining a screening EKG, as appropriate, and the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits).

Each of these components is further defined on the following pages.

Important 2009 Changes

Effective for dates of service on or after January 1, 2009, the screening EKG is no longer a required part of the IPPE. It is optional and may be performed as a result of a referral from an IPPE (as part of the educational, counseling, and referral services the beneficiary is entitled to during the beneficiary's IPPE visit). (See component # 7.) The screening EKG will be allowed only once in a beneficiary's lifetime.

The MIPPA legislation added a provision of "additional preventive services" under education, counseling, and referral services to allow for future covered preventive services. These preventive services may be added in the future through the National Coverage Determination (NCD) process.

NOTE: The IPPE does not include any clinical laboratory tests. The physician, qualified non-physician practitioner, or hospital may also provide and bill separately for the screening and other preventive services that are currently covered and paid for by Medicare Part B.

Components of the Initial Preventive Physical Examination

These seven components enable the Medicare provider to identify risk factors that may be associated with various diseases and to detect diseases early when outcomes are best. The provider is then able to educate and counsel the beneficiary about the identified risk factors and possible lifestyle changes that could have a positive impact on the beneficiary's health. The IPPE includes all of the following services furnished to a beneficiary by a physician or other qualified non-physician practitioner:

Component 1 -- Review of the beneficiary's medical and social history with attention to modifiable risk factors for disease detection

- Medical history includes, at a minimum, past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments; current medications and supplements, including calcium and vitamins; and family history, including a review of medical events in the beneficiary's family, including diseases that may be hereditary or place the individual at risk.
- Social history includes, at a minimum, history of alcohol, tobacco, and illicit drug use, diet, and physical activities.

Preparing Beneficiaries For the IPPE Visit

Providers can help beneficiaries get ready for the IPPE visit by suggesting they come prepared with the following information:

- Medical records, including immunization records.
- Family health history, in as much detail as possible.
- A full list of medications and supplements, including calcium and vitamins – how often and how much of each is taken.

Component 2 -- Review of the beneficiary's potential (risk factors) for depression and other mood disorders

This includes current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression. The physician or other qualified non-physician practitioner may select from various available standardized screening tests that are designed for this purpose and recognized by national professional medical organizations.

Component 3 -- Review of the beneficiary's functional ability and level of safety

This is based on the use of appropriate screening questions or methods. The physician or other qualified non-physician practitioner may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations. This review must include, at a minimum, the following areas:

- Hearing impairment
- Activities of daily living
- Falls risk
- Home safety

Component 4 -- A physical examination

This examination includes measurement of the beneficiary's height, weight, and blood pressure; measurement of body mass index (required service effective January 1, 2009); a visual acuity screen; and other factors as deemed appropriate by the physician or qualified non-physician practitioner, based on the beneficiary's medical and social history and current clinical standards.

Component 5 -- End-of-life planning

Effective for dates of service on or after January 1, 2009, the IPPE includes end-of-life planning as a required service, upon the beneficiary's consent. End-of-life planning is verbal or written information provided to the beneficiary regarding:

- The beneficiary's ability to prepare an advance directive in the case that an injury or illness causes the beneficiary to be unable to make health care decisions, and
- Whether or not the physician is willing to follow the beneficiary's wishes as expressed in the advance directive.

Component 6 -- Education, counseling, and referral based on the previous five components

Education, counseling, and referral, as determined appropriate by the physician or qualified non-physician practitioner, based on the results of the review and evaluation services described in the previous five components. Examples include the following:

- Counseling on diet if the beneficiary is overweight
- Education on prevention of chronic diseases
- Referral for smoking and tobacco-use cessation counseling

Component 7 -- Education, counseling, and referral for other preventive services

Education, counseling, and referral, including a brief written plan, such as a checklist, provided to the individual for obtaining a screening EKG, if appropriate, and the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits, as listed below:

- Bone mass measurements
- Cardiovascular screening blood tests
- Colorectal cancer screening tests
- Diabetes screening tests
- Diabetes outpatient self-management training services
- Medical nutrition therapy for individuals with diabetes or renal disease
- Pneumococcal, influenza, and hepatitis B vaccines and their administration
- Prostate cancer screening tests
- Screening for glaucoma
- Screening mammography
- Screening Pap test and screening pelvic examinations
- Ultrasound screening for abdominal aortic aneurysms

Each of the preventive services and screenings listed above are discussed in detail in this Guide.

Coverage Information

Medicare provides coverage of the IPPE for beneficiaries new to the Medicare Program. The IPPE is a preventive physical examination and is not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. **Medicare Part B does not provide coverage for routine physical examinations.**

Medicare provides coverage of the IPPE for all newly enrolled beneficiaries who receive the IPPE within the first 12 months after the effective date of their Medicare Part B coverage. However, only beneficiaries whose first Part B coverage period began on or after January 1, 2005 are eligible for the IPPE. The IPPE is covered only as a **one-time** benefit per Medicare Part B enrollee.

Who May Perform the IPPE?

Physician

A physician is defined as a doctor of medicine or osteopathy.

Qualified Non-Physician Practitioner

For the purpose of the IPPE, a qualified non-physician practitioner is a physician assistant, nurse practitioner, or clinical nurse specialist.

NOTE: Medicare beneficiaries who cancel their Medicare Part B coverage but later re-enroll in Medicare Part B are not eligible for the IPPE benefit.

The IPPE must be furnished by either a physician or a qualified non-physician practitioner.

Coverage of the IPPE visit is provided as a Medicare Part B benefit. For dates of service on or after January 1, 2009, the yearly Medicare Part B deductible is waived for the IPPE only. The deductible is not waived for the screening EKG. The coinsurance or copayment still applies to both the IPPE and the screening EKG.

Documentation

The physician or qualified non-physician practitioner must document that they provided, or provided and referred, all seven required components of the IPPE. The physician and/or qualified non-physician practitioner should use the appropriate screening tools normally used in a routine physician's practice.

If a separately identifiable, medically necessary E/M service is also performed, the physician and/or qualified non-physician practitioner must document this in the medical record. Follow the 1995 and 1997 E/M documentation guidelines, available at http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS website, for recording the appropriate clinical information in the beneficiary's medical record. Include all referrals and a written medical plan in this documentation.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Effective January 1, 2009, use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1 to report the IPPE and screening EKG services:

Table 1 – HCPCS Codes for the IPPE and Screening EKG

HCPCS Code	Code Descriptor
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventative physical examination with interpretation and report
G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventative physical examination
G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventative physical examination

NOTE: Effective January 1, 2009, the screening EKG is billable with HCPCS code(s) G0403, G0404, or G0405, when it is a result of a referral from an IPPE.

For IPPEs performed on or before December 31, 2008, report HCPCS code G0344 with one of the following HCPCS codes for the mandatory EKG: G0366, G0367, or G0368.

The HCPCS codes for the IPPE do not include other preventive services that are currently paid separately under Medicare Part B screening benefits. When Medicare providers perform these other preventive services, they must identify the services using the appropriate existing codes. The HCPCS/Current Procedural Terminology (CPT) codes for other preventive services will be provided later in this Guide.

Diagnosis Requirements

Although Medicare providers must report a diagnosis code on the claim, there are no specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are required for the IPPE and screening EKG. Medicare providers should choose an appropriate ICD-9-CM diagnosis code. Contact the local Medicare Contractor for further guidance.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS G code for the IPPE and screening EKG in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a Medicare provider qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Medicare will reimburse physicians or qualified non-physician practitioners for only **one** IPPE performed no later than 6 months after the date the beneficiary's first Medicare Part B coverage begins, but only if that coverage begins January 1, 2005 or after. Effective January 1, 2009, the eligibility period for receiving an IPPE has been extended from 6 months to 12 months following an individual's enrollment in Medicare Part B. Therefore, any beneficiaries who have not yet had an IPPE and whose initial enrollment in Medicare began in 2008 will be able to have an IPPE in 2009, as long as it is performed within 12 months of their initial enrollment.

When a physician or qualified non-physician practitioner provides a separately identifiable, medically necessary E/M service in addition to the IPPE, they may use CPT codes 99201 - 99215 depending on the clinical appropriateness of the encounter. The E/M code should be reported with modifier -25, identifying the service as a significant, separately identifiable, E/M service from the reported IPPE code.

If the primary physician or qualified non-physician practitioner does not perform a screening EKG as a result of the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring provider should ensure that the performing provider bills the appropriate HCPCS G code listed in Table 1 for the screening EKG, and not a CPT code in the 93000 series. When the primary physician or qualified non-physician practitioner performs the screening EKG, they shall document the results in the beneficiary's medical record to complete and bill for the IPPE benefit.

Should an additional medically necessary EKG in the 93000 series need to be performed on the same day as the IPPE, report the appropriate EKG CPT code(s) with modifier -59. This will indicate that the additional EKG is a distinct procedural service.

Other covered preventive services that are performed may be billed in addition to HCPCS code G0402 and the appropriate EKG HCPCS G code.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS G code for the IPPE benefit and screening EKG service in the HIPAA 837 Institutional electronic claim format. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) must report the HCPCS code for the IPPE to avoid application of the deductible (on RHC claims), assure payment for this service in addition to another encounter on the same day if they are both separate, unrelated and appropriate, and to update the Common Working File (CWF) record to track this once in a lifetime benefit.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

When a physician or qualified non-physician practitioner provides a separately identifiable, medically necessary E/M service in addition to the IPPE, they may use CPT code(s) 99201 - 99215 depending on the clinical appropriateness of the encounter. The E/M code should be reported with modifier -25. Hospitals subject to the Outpatient Prospective Payment System (OPPS) that bill for both the technical component of the screening EKG (G0404) and the IPPE itself (G0402) must report modifier -25 with HCPCS code G0402.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for the IPPE and screening EKG (HCPCS code G0404, tracing only), when submitted on the following Types of Bills (TOBs) listed in Table 2:

Table 2 – Facility Types and Types of Bills for IPPE and Screening EKG

Facility Type	Type of Bill
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X
Hospital Outpatient	13X
Skilled Nursing Facility (SNF) Inpatient Part B	22X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	73X
CAH Outpatient*	85X

***NOTE:** Medicare pays all CAHs for the technical or facility component of the IPPE itself. Medicare also pays CAHs for the technical component of the EKG (the tracing only) if the screening EKG is performed.

Medicare pays only Method II CAHs for the professional component of the IPPE (HCPCS code G0402) itself (in addition to the facility payment) in revenue code 0960. If a Method II CAH performs the screening EKG, Medicare may also pay for the interpretation of the EKG (in addition to the payment for the tracing) when billed on 71X, 73X, and 85X (CAH Method II) TOBs in revenue codes 0985 or 0986.

Additional Billing Instructions for Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs)

- RHCs and FQHCs should follow normal billing procedures for RHC/FQHC services.
- Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at the same location constitute a single visit. In rare circumstances, an RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the IPPE when they are performed on the same day, when the encounters are separate, unrelated, and appropriate.
- The technical component of the EKG performed at an independent RHC/FQHC is billed to the carrier/AB MAC. For RHCs and FQHCs, there is no separate payment for the professional component of the EKG and no separate billing of it.
- The technical component of the EKG performed at a provider-based RHC/FQHC is billed on the applicable TOB, as listed in Table 3, and submitted to the FI/AB MAC using the base provider number and billing instructions.
- RHCs and FQHCs use revenue code 052X. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520.
- The professional portion of the service billed to the FI or Part A MAC on TOBs 71X or 73X should be made using the appropriate site of service revenue code in the 052X series and must include the HCPCS code.

Table 3 – Facility Types and Types of Bills for RHCs and FQHCs

Facility Type	Type of Bill	Basis of Payment
Rural Health Clinic (RHC)	71X	All-inclusive Rate **(for professional services)**
Federally Qualified Health Center (FQHC)	73X	All-inclusive Rate **(for professional services)**

NOTE: For RHCs and FQHCs, there is no separate payment for the screening EKG.

Reimbursement Information

General Information

Medicare provides coverage of the IPPE visit as a Part B benefit. Medicare pays for the HCPCS codes for the IPPE and screening EKG under the Medicare Physician Fee Schedule (MPFS). **For dates of service on or after January 1, 2009, the annual Part B deductible is waived for the IPPE (HCPCS code G0402). However, the deductible and coinsurance still apply to HCPCS codes G0344, G0366, G0367, G0368, G0403, G0404, and G0405.**

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Additional information about OPPS can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS on the CMS website.

Hospital Outpatient Department: Ambulatory Payment Classification (APC) Group, effective January 1, 2009:

G0402 will be assigned to APC 0605; and

G0404 will be assigned to APC 0099.

Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the APC group to which the service is assigned.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for the IPPE is paid under the Medicare Physician Fee Schedule (MPFS) when billed to the carrier/AB MAC.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for the IPPE depends on the type of facility providing the service. Table 4 lists the type of payment that facilities receive for the IPPE:

Table 4 – Facility Types and Types of Payments Received by Facilities for the IPPE

Facility Type	Basis of Payment
Hospital Outpatient	Outpatient Prospective Payment System (OPPS), for hospitals subject to the OPPS. Hospitals not subject to OPPS are paid under current methodologies.
Critical Access Hospital (CAH)	Reasonable Cost Basis (Paid at 101% of their reasonable cost)
Skilled Nursing Facility (SNF)	Payment for the technical component of the EKG based on the Medicare Physician Fee Schedule (MPFS)
Rural Health Clinic (RHC)	All-inclusive Rate
Federally Qualified Health Center (FQHC)	All-inclusive Rate

NOTE: Maryland hospitals will be reimbursed for inpatient or outpatient services according to the Maryland State Cost Containment Plan.

NOTE: For RHCs and FQHCs, there is no separate payment for the screening EKG and no separate billing of it. The IPPE is the only HCPCS for which the deductible is waived under this benefit and for which HCPCS codes are separately reported.

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of the IPPE:

- The beneficiary's Medicare Part B coverage did not begin on or after January 1, 2005.
- A second IPPE is billed for the same beneficiary.
- The IPPE was performed outside of the first 12 months of Medicare Part B coverage.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Advance Beneficiary Notice of Noncoverage (ABN) as Applied to the IPPE:

If a second IPPE is billed for the same beneficiary, it would be denied based on section 1861(s)(2) of the Act, since the IPPE is a one-time benefit, and an ABN would not be required in order to hold the beneficiary liable for the cost of the second IPPE.

Effective for beneficiaries whose IPPE is provided January 1, 2005 through December 31, 2008, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory 6-month period has lapsed based on section 1862(a)(1)(K) of the Act, since Medicare is statutorily prohibited from paying for an IPPE outside the initial six-month period.

Effective for IPPEs performed on or after January 1, 2009, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory 12-month period has lapsed based on the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amendment to section 1862(a)(1)(K) of the Act, since Medicare is statutorily prohibited from paying for an IPPE outside the initial 12-month period.

For more information about the Advance Beneficiary Notice of Noncoverage (ABN), please refer to Reference Section G of this publication.

Initial Preventive Physical Examination

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Documentation Guidelines for Evaluation & Management Services
http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Final Rule, 42 CFR Parts 409, 410, et al: Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions; Final Rule
http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1204957&intNumPerPage=10

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Medicare Claims Processing Manual – Pub. 100-04, Chapter 12, Section 30.6.1.1
http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 80
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

Beneficiary-related resources can be found in Reference F of this Guide.

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

Outpatient Prospective Payment System Information
http://www.cms.hhs.gov/HospitalOutpatientPPS

Partnership for Prevention
Partnership for Prevention has developed educational materials to assist health care professionals in delivering the "Welcome to Medicare" visit.
http://www.prevent.org

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies, regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Notes

Ultrasound Screening for Abdominal Aortic Aneurysms

Overview

An aneurysm is an abnormal bulge or "ballooning" in the wall of an artery. Most aneurysms occur in the aorta, the main artery that carries blood from the heart to the rest of the body. An aneurysm that occurs in the aorta in the abdomen is called an abdominal aortic aneurysm (AAA). Three out of four aortic aneurysms are AAAs.

An AAA occurs when the aorta below the renal arteries expands to a maximal diameter of 3.0 centimeters (cm) or greater. AAAs may be asymptomatic for years, but if left untreated, the continuing extension and thinning of the vessel wall may eventually result in a rupture of the aneurysm. Ultrasound screening of the abdomen has been shown to be a reliable and accurate method for detecting AAAs.

Medicare's coverage of ultrasound screening for AAAs was designated in section 5112 of the Deficit Reduction Act (DRA) of 2005. Effective for services furnished on or after January 1, 2007, Medicare will pay for a one-time only preventive ultrasound screening for the early detection of AAAs for at-risk beneficiaries, resulting from a referral from an Initial Preventive Physical Examination (IPPE).

IMPORTANT NOTE

Only Medicare beneficiaries who receive a referral for the AAA ultrasound screening as a result of the IPPE will be covered for the AAA benefit.

Ultrasound Screening for Abdominal Aortic Aneurysms

The term "ultrasound screening for abdominal aortic aneurysm" is defined as the following:

1. A procedure using sound waves (or other procedures using alternative technologies, of commensurate accuracy and cost, as specified by CMS through the national coverage determination process) provided for the early detection of AAA; and
2. Includes a physician's interpretation of the results of the procedure.

Risk Factors

An AAA can develop in anyone; however, risk factors for developing an AAA include the following:

- Male gender
- Age 65 or older
- History of ever smoking (at least 100 cigarettes in a person's lifetime)
- Family history of AAAs
- Coronary heart disease
- Hypercholesterolemia
- Hypertension
- Cerebrovascular disease

Coverage Information

Medicare provides coverage of a one-time preventive ultrasound screening for the early detection of an AAA for eligible beneficiaries who meet the following criteria:

- The beneficiary receives a referral for an ultrasound screening as a result of an IPPE;
- The beneficiary receives a referral from a provider or supplier who is authorized to provide covered ultrasound diagnostic services;
- The beneficiary has not been previously furnished an ultrasound screening under the Medicare Program; and
- The beneficiary is included in at least **one** of the following risk categories:
  - The beneficiary has a family history of AAAs;
  - The beneficiary is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime; or
  - The beneficiary manifests other risk factors in a beneficiary category recommended for ultrasound screening by the United States Preventive Services Task Force (USPSTF) regarding AAAs, as specified by the Secretary of Health and Human Services through the national coverage determination process.

Medicare provides coverage for the ultrasound screening for AAA as a Medicare Part B benefit. The coinsurance or copayment applies. There is no Medicare Part B deductible for this benefit.

Documentation

Medical record documentation must show that the ultrasound screening was ordered by a physician or qualified non-physician practitioner treating an asymptomatic beneficiary for the purpose of early detection of an AAA as a result of the IPPE. The Medicare provider should document the appropriate supporting procedure and diagnosis codes.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) code listed in Table 1 is used to report the AAA ultrasound screening service:

Table 1 – HCPCS Code for AAA Ultrasound Screening Service

HCPCS Code	Code Descriptor
G0389	Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening

Diagnosis Requirements

Although Medicare providers must report a diagnosis code on the claim, there are no specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are required for the AAA ultrasound screening. Providers should choose an appropriate ICD-9-CM diagnosis code. Contact the local Medicare Contractor for further guidance.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report HCPCS code G0389 and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs with HCPCS code G0389, Medicare providers must report the appropriate revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for the AAA ultrasound screening service when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 2:

Table 2 – Facility Types, Types of Bills, and Revenue Codes for AAA Ultrasound Screening Service

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X	040X
Hospital Outpatient	13X	040X

Facility Type	Type of Bill	Revenue Code
SNF Outpatient	22X	040X
Rural Health Clinic (RHC)	23X	040X
Federally Qualified Health Center (FQHC)	71X	052X See Additional Billing Instructions for RHCs and FQHCs
CAH**	73X	052X See Additional Billing Instructions for RHCs and FQHCs
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	85X	040X
Indian Health Service (IHS) Provider	12X & 13X	040X
IHS Inpatient Part B including CAH	12X	024X
IHS CAH	85X	051X

***NOTE:** The Skilled Nursing Facility (SNF) consolidated billing provision allows separate Medicare Part B payment for ultrasound screening services for beneficiaries that are in skilled Part A SNF stays; however, the SNF must submit these services on a 22X bill type. Ultrasound screening services provided by other provider types must be reimbursed by the SNF.

****NOTE:** Method I - All technical components are paid using standard institutional billing practices.

Method II - Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X. **(This pertains to physicians/practitioners who have reassigned their billing rights to the Method II CAH.)**

Additional Billing Instructions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

RHCs and FQHCs should follow these additional billing instructions to ensure that proper payment is made for services and to allow the Common Working File (CWF) to perform age and frequency editing.

- **Technical Component** for Provider-Based RHCs and FQHCs:
  - The base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **Technical Component** for Independent RHCs and FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.

- **Professional Component** for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a physician or qualified non-physician practitioner furnishes an ultrasound screening for AAA within an RHC/FQHC, the screening is considered an RHC/FQHC service.
  - The provider of an ultrasound screening for AAA service must bill the FI/AB MAC under bill type 71X or 73X respectively.
  - If the ultrasound screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI or AB MAC using the appropriate site of service revenue code in the 052X revenue code series and must include HCPCS code G0389 for the appropriate application of deductible. FQHC services are always exempt from the Part B deductible; however, RHCs are exempt from the deductible for this service.

Reimbursement Information

General Information

There is no Medicare Part B deductible. However, the coinsurance or copayment is applicable.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare reimburses the ultrasound screening procedure for AAA under the Medicare Physician Fee Schedule (MPFS), when the provider bills the carrier/AB MAC.

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for the ultrasound screening for AAAs depends on the type of facility providing the service. Table 3 lists the type of payment that facilities receive for the AAA ultrasound screening service:

Table 3 – Facility Payment Methodology for Ultrasound Screening for AAA

If the Facility is a…	Then Payment Is Based On...
Hospital Subject to the Outpatient Prospective Payment System (OPPS)	OPPS
Critical Access Hospital (CAH), Method I or Method II – Technical Component only	101% of reasonable cost
Critical Access Hospital (CAH), Method II – Professional Component only	115% of non-facility rate of Medicare Physician Fee Schedule (MPFS)
Indian Health Service (IHS) Provider – Outpatient	OMB-approved Outpatient Per Visit All-Inclusive Rate (AIR)
IHS Provider – Hospital Inpatient Part B	All-Inclusive Inpatient Ancillary Per Diem Rate
IHS CAH	101% of the All-Inclusive Facility Specific Per Visit Rate

If the Facility is a…	Then Payment Is Based On...
IHS CAH – Hospital Inpatient Part B	101% of the All-Inclusive Facility Specific Per Diem Rate
Indian Health Service (IHS) Provider – Outpatient	OMB-approved Outpatient Per Visit AIR
Rural Health Clinic (RHC)*	All-Inclusive Encounter Rate
Skilled Nursing Facility (SNF)**	Non-Facility Rate on the MPFS
Federally Qualified Health Center (FQHC)*	All-Inclusive Encounter Rate
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	94% of provider submitted charges or according to the terms of the Maryland Waiver

***NOTE:** If the ultrasound screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI/AB MAC using TOBs 71X and 73X, respectively, and the appropriate site of service revenue code in the 052X revenue code series. If the ultrasound screening is provided in an independent RHC or freestanding FQHC, the practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID following instructions for submitting practitioner claims to the carrier/AB MAC. If the ultrasound screening is provided in a provider-based RHC/FQHC, the base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID, following instructions for submitting claims to the FI/AB MAC from the base provider.

****NOTE:** The SNF consolidated billing provision allows separate Part B payment for ultrasound screening services for beneficiaries that are in skilled Part A SNF stays; however, the SNF must submit these services on a 22X bill type. Ultrasound screening services provided by other provider types must be reimbursed by the SNF.

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of AAA ultrasound screening:

- The beneficiary did not receive a referral for the AAA ultrasound screening as a result of the IPPE.
- The beneficiary previously has received a covered AAA ultrasound screening.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the web. Providers can obtain additional information about claims from the carrier/AB MAC or FI/AB MAC.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice Of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Ultrasound Screening for Abdominal Aortic Aneurysms

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 110
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
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Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

National Provider Identifier Information
http://www.cms.hhs.gov/NationalProvIdentStand

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies, regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Beneficiary-related resources can be found in Reference F of this Guide.

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

Screening for Abdominal Aortic Aneurysm: Recommendation Statement
http://www.ahrq.gov/clinic/uspstf05/aaascr/aaars.htm

Society for Vascular Surgery
http://www.vascularweb.org

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Cardiovascular Screening Blood Tests

Overview

Every year, thousands of Americans die of heart disease and stroke. Millions more currently live with one or more types of cardiovascular disease, including, coronary heart disease, stroke, high blood pressure, congestive heart failure, congenital cardiovascular defects, and hardening of the arteries. Heart disease and stroke are also among the leading causes of disability for both men and women in the United States.

Recognizing the need for early detection to effectively combat the risks of cardiovascular disease, Congress expanded preventive services to include the coverage of cardiovascular screening blood tests. Section 612 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established Medicare coverage of cardiovascular screening blood tests.

On January 1, 2005, Medicare began providing coverage of cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke. These tests can help determine a beneficiary's cholesterol and other blood lipid levels such as triglycerides. CMS recommends that all eligible beneficiaries take advantage of this coverage, which can determine whether beneficiaries are at high risk for cardiovascular disease.

Stand Alone Benefit

It is important to emphasize that the cardiovascular screening benefit covered by Medicare is a stand alone billable service separate from the Initial Preventive Physical Examination (IPPE) and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

The cardiovascular screening blood tests covered by Medicare include the following:

- Total Cholesterol Test
- Cholesterol Test for High Density Lipoproteins
- Triglycerides Test

NOTE: The beneficiary must fast for 12 hours prior to testing. Other cardiovascular screening blood tests remain non-covered.

Risk Factors

The coverage of cardiovascular screening blood tests presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing heart disease and how they can control their cholesterol levels through diet, physical activity, or if necessary with medication. While anyone can develop cardiovascular disease, some factors that may put individuals at a higher risk include the following:

- Diabetes
- Family history of cardiovascular disease
- High fat diet
- History of previous heart disease
- Hypercholesterolemia (high cholesterol)
- Hypertension
- Lack of exercise

- Obesity
- Smoking
- Stress

Coverage Information

Medicare provides coverage of cardiovascular screening blood tests for all asymptomatic beneficiaries every 5 years (i.e., at least 59 months after the last covered screening tests). The physician or qualified non-physician practitioner treating the beneficiary must order the screening blood tests for the purpose of early detection of cardiovascular disease. The beneficiary must have no apparent signs or symptoms of cardiovascular disease.

Medicare provides coverage of cardiovascular screening blood tests as a Part B benefit. The beneficiary will pay nothing for the blood tests (there is no coinsurance or copayment and no deductible for this benefit).

Who Are Qualified Physicians and Non-Physician Practitioners?

Physician

A physician is defined as a doctor of medicine or osteopathy.

Qualified Non-Physician Practitioner

For the purpose of the cardiovascular screening blood test, a qualified non-physician practitioner is a physician assistant, nurse practitioner, or clinical nurse specialist.

NOTE: Laboratories must offer the ability to order a lipid panel without the low density lipoprotein (LDL) measurement. The frequency limit for each test applies regardless of whether tests are provided in a panel or individually.

Documentation

Medical record documentation must show that a physician or qualified non-physician practitioner treating an asymptomatic beneficiary for the purpose of early detection of cardiovascular disease ordered the screening tests. The beneficiary must have the test performed after a 12-hour fast, and the Medicare provider should document the appropriate supporting procedure and diagnosis codes.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Current Procedural Terminology (CPT) codes listed in Table 1 to report the cardiovascular screening blood tests:

Table 1 – CPT Codes for Cardiovascular Screening Blood Tests

CPT Code	Code Descriptor
80061	Lipid Panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)

CPT Code	Code Descriptor
82465	Cholesterol, serum or whole blood, total (For high density lipoprotein HDL, use 83718)
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
84478	Triglycerides

NOTE: The tests should be ordered as a lipid panel; however, they may be ordered individually.

Diagnosis Requirements

Medicare providers must report one or more of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening ("V") diagnosis code(s) for cardiovascular screening blood tests:

Table 2 – Diagnosis Codes for Cardiovascular Screening Blood Tests

ICD-9-CM Diagnosis Code	Code Descriptor
V81.0	Special screening for ischemic heart disease
V81.1	Special screening for hypertension
V81.2	Special screening for other and unspecified cardiovascular conditions

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate CPT code, and the appropriate diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exemption to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, the Medicare provider must report the appropriate CPT code, the appropriate revenue code, and the appropriate diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for the cardiovascular screening blood tests when submitted on the following Type of Bills (TOBs) listed in Table 3:

Table 3 – Facility Types and Types of Bills for Cardiovascular Screening Blood Tests

Facility Type	Type of Bill
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X
Hospital Outpatient	13X
Hospital Non-patient Laboratory Specimens including CAH	14X
Skilled Nursing Facility (SNF) Inpatient Part B	22X
SNF Outpatient	23X
CAH	85X

The service is covered when it is performed on an inpatient or outpatient basis in a hospital, CAH, or SNF.

Special Billing Note

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) may only bill for RHC or FQHC services; laboratory services are not within the scope of the RHC or FQHC benefit. However, if the RHC or FQHC is provider-based, and the base provider furnishes the lab test apart from the RHC or FQHC, then the base provider may bill the lab test using the base provider's provider ID number. Payment will be made to the base provider, not the RHC or FQHC. If the facility is freestanding, then the individual practitioner bills the carrier/AB MAC for the lab test using the provider ID number.

Reimbursement Information

General Information

Medicare provides coverage of the cardiovascular screening blood tests as a Medicare Part B benefit. The beneficiary will pay nothing for the blood tests (there is no coinsurance or copayment and no Medicare Part B deductible for this benefit).

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare provides reimbursement for the cardiovascular screening blood tests under the Medicare Clinical Laboratory Fee Schedule, when the Medicare provider bills the carrier/AB MAC.

> Additional information about the Clinical Laboratory Fee Schedule can be found at http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for the cardiovascular screening blood tests depends on the type of facility providing the service. Table 4 lists the type of payment that facilities receive for cardiovascular screening blood tests:

Table 4 – Facility Payment Methodology for Cardiovascular Screening Blood Tests

If the Facility Is a…	Then Payment is Based On…
Critical Access Hospital (CAH)	Reasonable Cost Basis **(Paid at 101% of their reasonable cost)**
Hospital	Clinical Laboratory Fee Schedule
Skilled Nursing Facility (SNF)	Clinical Laboratory Fee Schedule

NOTE: Maryland hospitals will be reimbursed for inpatient or outpatient services according to the Maryland State Cost Containment Plan.

Reasons for Claim Denial

The following are examples of when Medicare may deny coverage of cardiovascular screening blood tests:

- The beneficiary received a covered lipid panel during the past five years.
- The beneficiary received the same individual cardiovascular screening blood test during the past five years.

> **Medicare Contractor Contact Information**
>
> To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

- Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Cardiovascular Screening Blood Tests

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Clinical Laboratory Fee Schedule Information
http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Final Rule, 42 CFR Parts 409, 410, et al: Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions
http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1204957&intNumPerPage=10

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Heart Disease and Stroke: The Nation's Leading Killers
http://www.cdc.gov/nccdphp/publications/AAG/dhdsp.htm

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 100
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule.
http://www.cms.hhs.gov/center/provider.asp

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The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

Beneficiary-related resources can be found in Reference F of this Guide.

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

National Provider Identifier Information
http://www.cms.hhs.gov/NationalProvIdentStand

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies, regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Notes

Diabetes Screening Tests, Supplies, Self-Management Training, Medical Nutrition Therapy, and Other Services

Overview

Millions of people have diabetes and don't know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, pregnancy complications, and death related to pneumonia and flu. Diabetes is the leading cause of blindness among adults, and the leading cause of end-stage renal disease.

The good news is that scientific evidence now shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay many of the illnesses and complications associated with diabetes. Section 613 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 expanded preventive services covered by Medicare to include preventive screening for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes. This benefit will help to improve the quality of life for Medicare beneficiaries by preventing more severe conditions that can occur without proper treatment from undiagnosed or untreated diabetes.

Diabetes Mellitus

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- A fasting blood glucose greater than or equal to 126 mg/dL on two different occasions.
- A 2-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions.
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Stand Alone Benefit

It is important to emphasize that the diabetes screening benefit covered by Medicare is a stand alone billable service separate from the Initial Preventive Physical Examination (IPPE) and **does not** have to be obtained within the first 12 months of a beneficiary's Medicare Part B coverage.

Pre-diabetes

Pre-diabetes is a condition of abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100-125 mg/dL or a 2-hour post-glucose challenge of 140-199 mg/dL. The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance.

The diabetes screening blood tests covered by Medicare include the following:

- A fasting blood glucose test

AND

- A post-glucose challenge test; not limited to
- An oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults

OR

- A 2-hour post-glucose challenge test alone

Risk Factors

To be eligible for the diabetes screening tests, beneficiaries must have any of the following risk factors or at least two of the following characteristics:

Beneficiaries are considered at risk for diabetes if they have any of the following risk factors:

- Hypertension,
- Dyslipidemia,
- Obesity (a body mass index greater than or equal to 30kg/m^2), or
- Previous identification of an elevated impaired fasting glucose or glucose tolerance.

OR

Beneficiaries who have a risk factor consisting of at least two of the following characteristics:

- Overweight (a body mass index greater than 25 but less than 30kg/m^2),
- Family history of diabetes,
- Age of 65 or older, or
- A history of gestational diabetes mellitus, or delivery of a baby weighing greater than 9 pounds.

Coverage Information

Effective for services provided on or after January 1, 2005, Medicare provides coverage of diabetes screening tests for beneficiaries in the risk groups previously listed or those diagnosed with pre-diabetes.

Pre-diabetes is a condition of abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100-125 mg/dL or a 2-hour post-glucose challenge of 140-199 mg/dL. The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance.

Medicare provides coverage for diabetes screening tests with the following frequency:

Who Are Qualified Physicians and Non-Physician Practitioners?

Physician

A physician is defined as a doctor of medicine or osteopathy.

Qualified Non-Physician Practitioner

For the purpose of the diabetes screening blood tests, a qualified non-physician practitioner is a physician assistant, nurse practitioner, or clinical nurse.

Beneficiaries diagnosed with pre-diabetes

Medicare provides coverage for a maximum of 2 diabetes screening tests within a 12-month period (but not less than 6 months apart) for beneficiaries diagnosed with pre-diabetes.

Beneficiaries previously tested but not diagnosed as pre-diabetic or who have never been tested

Medicare provides coverage for 1 diabetes screening test within a 12-month period (i.e., at least 11 months have passed following the month in which the last Medicare-covered diabetes screening test was performed) for beneficiaries who were previously tested and were not diagnosed with pre-diabetes, or who have never been tested.

Medicare provides coverage for diabetes screening as a Medicare Part B benefit after a referral from a physician or qualified non-physician practitioner for an individual at risk for diabetes. The beneficiary will pay nothing for this screening (there is no coinsurance or copayment and no deductible for this benefit).

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Current Procedural Terminology (CPT) codes listed in Table 1 to report the diabetes screening tests:

Table 1 – CPT Codes for Diabetes Screening Tests

CPT Code	Code Descriptor
82947	Glucose; quantitative, blood (except reagent strip)
82950	Glucose; post glucose dose (includes glucose)
82951	Glucose; tolerance test (GTT), three specimens (includes glucose)

NOTE: Medicare makes payment for these procedure codes under the Clinical Laboratory Fee Schedule.

Diagnosis Requirements

Medicare providers must report the screening ("V") diagnosis code V77.1 (Special Screening for Diabetes Mellitus). Effective April 1, 2005, when a Medicare provider submits a claim for diabetes screening where the beneficiary meets the definition of pre-diabetes, they should report the appropriate diagnosis code with modifier TS. The appropriate CPT code(s) are also required on the claim.

See the National Correct Coding Initiative Edits web page for currently applicable bundled carrier processed procedures at http://www.cms.hhs.gov/NationalCorrectCodInitEd on the CMS website.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians or qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate CPT code and the corresponding diagnosis code(s) in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate CPT code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code(s) in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for the diabetes screening tests when submitted on the following Types of Bills (TOBs) listed in Table 2:

Table 2 – Facility Types and Types of Bills for Diabetes Screening Services

Facility Type	Type of Bill
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X
Hospital Outpatient	13X
Hospital Non-patient Laboratory Specimens including CAH	14X
Skilled Nursing Facility (SNF) Inpatient Part B	22X
SNF Outpatient	23X
CAH Outpatient	85X

Special Billing Instructions

- Skilled Nursing Facility (SNF) - When furnished to a beneficiary in a SNF Part A covered stay, the SNF must bill the FI/AB MAC using bill type 22X.

- Generally, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) cannot bill for non-RHC/FQHC services. The diabetes screening tests are considered non-RHC/FQHC services. However, if the RHC or FQHC is provider-based, then the base provider can bill the lab tests to the FI/AB MAC, using the base provider's NPI. The FI/AB MAC will make payment to the base provider, not the RHC/FQHC. If the facility is freestanding, then the individual practitioner bills the carrier/AB MAC for the lab tests using the practitioner's ID number.

Reimbursement Information

General Information

Reimbursement of diabetes screening tests is made under the Clinical Laboratory Fee Schedule.

Medicare will reimburse Critical Access Hospitals (CAHs) at 101 percent of their reasonable cost.

Medicare will reimburse Maryland hospitals according to the Maryland State Cost Containment Plan.

Additional information about the Clinical Laboratory Fee Schedule can be found at http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for diabetes screening test services is based on the Clinical Laboratory Fee Schedule.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for diabetes screening test services is based on the Clinical Laboratory Fee Schedule.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of diabetes screening tests:

- The beneficiary is not at risk for diabetes.
- The beneficiary has already had two diabetes screenings within the past year and has not been identified as having pre-diabetes.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Providers can obtain additional information about claims from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

DIABETES SUPPLIES

Medicare provides coverage for the following diabetes supplies.

Supplies Covered

Medicare provides limited coverage, based on established medical necessity requirements, for these diabetes supplies:

- Blood glucose self-testing equipment and associated accessories
- Therapeutic Shoes
  - One pair of depth-inlay shoes and three pairs of inserts

  OR

  - One pair of custom-molded shoes (including inserts), if the beneficiary cannot wear depth-inlay shoes because of a foot deformity, and two additional pairs of inserts within the calendar year
- Insulin pumps and the insulin used in the pumps

NOTE: In certain cases, Medicare may also pay for separate inserts or shoe modifications.

Blood Glucose Monitors and Associated Accessories

Medicare provides coverage of blood glucose monitors and associated accessories and supplies for insulin-dependent and non-insulin dependent persons with diabetes based on medical necessity.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 3 to report blood glucose self-testing equipment and supplies:

Table 3 – HCPCS Codes for Blood Glucose Self-Testing Equipment and Supplies

HCPCS Code	Code Descriptor
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4259	Lancets, per box of 100
E0607	Home blood glucose monitor

Coverage Information

Medicare provides coverage for diabetes-related durable medical equipment (DME) and supplies as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier does not accept assignment, the amount the beneficiary pays may be higher. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

For information regarding Medicare's medical necessity requirements and claim filing information, please contact the local DME MAC. Visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website for the name, address, and telephone number of the local DME MAC.

For Medicare to cover a blood glucose monitor and associated accessories, the provider must provide the beneficiary with a prescription that includes the following information:

- A diagnosis of diabetes,
- The number of test strips and lancets required for one month's supply,
- The type of meter required (i.e., if a special meter for vision problems is required, the physician should state the medical reason for the required meter),
- A statement that the beneficiary requires insulin or does not require insulin, and
- How often the beneficiary should test the level of blood sugar.

Insulin-Dependent

For beneficiaries who are insulin-dependent, Medicare provides coverage for the following:

- Up to 100 test strips and lancets every month
- One lancet device every 6 months

Non-Insulin Dependent

For beneficiaries who are non-insulin dependent, Medicare provides coverage for the following:

- Up to 100 test strips and lancets every 3 months
- One lancet device every 6 months

NOTE: Medicare allows additional test strips and lancets if deemed medically necessary. However, Medicare will not pay for any supplies that are not requested or were sent automatically from suppliers. This includes lancets, test strips, and blood glucose monitors.

Therapeutic Shoes

Medicare requires that the physician who is managing a patient's diabetic condition document and certify the beneficiary's need for therapeutic shoes. Coverage for therapeutic shoes under Medicare Part B requires that the following conditions are met:

- The shoes are prescribed by a podiatrist or other qualified physician.
- The shoes must be furnished and fitted by a podiatrist or other qualified individual, such as a pedorthist, prosthetist, or orthotist.

Coverage Information

Medicare provides coverage for depth-inlay shoes, custom-molded shoes, and shoe inserts for beneficiaries with diabetes as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the Medicare provider does not accept assignment, the amount the beneficiary pays may be higher, and the beneficiary may be required to pay the full amount at the time of service. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

The physician must certify that the beneficiary meets the following criteria:

- The beneficiary must have diabetes
- The beneficiary must have at least one of the following conditions:
  - Partial or complete amputation of a foot,
  - Foot ulcers,

- Calluses that could lead to foot ulcers,
- Nerve damage from diabetes and signs of calluses,
- Poor circulation, or
- A deformed foot.

The beneficiary must also be treated under a comprehensive plan of care to receive coverage.

For each individual, coverage of the footwear and inserts is limited to one of the following within one calendar year:

- No more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes)
- No more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 4 to report therapeutic shoes:

Table 4 – HCPCS Codes for Therapeutic Shoes

HCPCS Code	Code Descriptor
A5512	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each
A5513	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each

Insulin Pumps

Insulin pumps that are worn outside the body and the insulin used with the pump may be covered for some beneficiaries who have diabetes and who meet certain conditions. Insulin pumps are available through a prescription. Beneficiaries must meet either of the criteria listed in Table 5 to receive coverage for an external infusion pump for insulin and related drugs and supplies:

Table 5 – External Infusion Pump for Insulin and Related Drugs and Supplies Coverage Criterion

Criteria A	Criteria B
The beneficiary has completed a comprehensive diabetes education program, and has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day), with frequent self-adjustments of insulin doses for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to the initiation of the insulin pump, and meets one or more of the following criteria while on the multiple daily injection regimen: ▸ Glycosylated hemoglobin level (HbA1c) > 7.0 percent; ▸ History of recurring hypoglycemia; ▸ Wide fluctuations in blood glucose before mealtime; ▸ Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL; or ▸ History of severe glycemic excursions.	The patient with diabetes has been on a pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.

In addition to meeting Criterion A or B above, the beneficiary must meet the following general requirements:

The patient with diabetes must be Insulinopenic per the updated fasting C-peptide testing requirement, or, as an alternative, must be beta cell autoantibody positive.

Updated fasting C-peptide testing requirement:

- Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method.
- For patients with renal insufficiency and creatinine clearance (actual or calculated from age, gender, weight, and serum creatinine) ≤50 ml/minute, Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 200 percent of the lower limit of normal of the laboratory's measurement method.
- Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose ≤225 mg/dL.
- Levels only need to be documented once in the medical records.

Continued coverage of the insulin pump would require that the beneficiary has been seen and evaluated by the treating physician at least every three months. A physician who manages multiple patients with Continuous Subcutaneous Insulin Infusion (CSII) pumps and who works closely with a team including nurses, diabetes educators, and dietitians who are knowledgeable in the use of CSII must order the pump.

Coverage Information

The Medicare Part B deductible and coinsurance or copayment applies. When covered, Medicare will pay for the insulin pump, as well as the insulin used with the insulin pump.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 6 to report insulin pumps and supplies:

Table 6 – HCPCS Codes for Insulin Pumps and Supplies

HCPCS Code	Code Descriptor
K0455	Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol)
K0552	Supplies for external drug infusion pump, syringe type cartridge, sterile, each
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each
J1817	Insulin for administration through DME (i.e., insulin pump) per 50 units

Billing Requirements

Billing and Coding Requirements Specific to Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

Beneficiaries can no longer file their Medicare claim forms for diabetes supplies. The Medicare provider must file the form on behalf of the beneficiary.

For information regarding Medicare's medical necessity requirements and claim filing information, please contact the local DME MAC. Visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website for the name, address, and telephone number of the local DME MAC.

Reimbursement Information

General Information

Reimbursement of diabetes supplies is made by the four DME MACs based on the DME Fee Schedule. Medicare Part B deductible and coinsurance apply. Medicare pays 80 percent of the approved Fee Schedule.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of diabetes supplies:

- The beneficiary does not have a prescription for the supplies.
- The beneficiary exceeds the allowed quantity of the supplies.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the DME MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

DIABETES SELF-MANAGEMENT TRAINING (DSMT) SERVICES

Medicare provides coverage of diabetes self-management training (DSMT) services for beneficiaries who have been recently diagnosed with diabetes, determined to be at risk for complications from diabetes, or were previously diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible for coverage under the Medicare Program.

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of DMST services when a certified provider who meets certain quality standards furnishes these services. DSMT services are intended to educate beneficiaries in the successful self-management of diabetes. A qualified DSMT program includes the following services:

- Instructions in self-monitoring of blood glucose,
- Education about diet and exercise,
- An insulin treatment plan developed specifically for insulin dependent patients, and
- Motivation for patients to use the skills for self-management.

DSMT services are aimed toward individuals with Medicare who have recently been impacted in any of the following situations by diabetes:

- Problems controlling blood sugar,
- Beginning diabetes medication, or switching from oral diabetes medication to insulin,
- Diagnosed with eye disease related to diabetes,
- Lack of feeling in feet or other foot problems such as ulcers or deformities, or an amputation has been performed,
- Treated in an emergency room or have stayed overnight in a hospital because of diabetes, or
- Diagnosed with kidney disease related to diabetes.

The DSMT program should educate beneficiaries in the successful self-management of diabetes as well as be capable of meeting the needs of its patients on the following subjects:

- Information about diabetes and treatment options,
- Diabetes overview/pathophysiology of diabetes,
- Nutrition,
- Exercise and activity,
- Managing high and low blood sugar,
- Diabetes medications, including skills related to the self-administration of injectable drugs,
- Self-monitoring and use of the results,
- Prevention, detection, and treatment of chronic complications,
- Prevention, detection, and treatment of acute complications,
- Foot, skin, and dental care,
- Behavioral change strategies, goal setting, risk factor reduction, and problem solving,
- Preconception care, pregnancy, and gestational diabetes,
- Relationships among nutrition, exercise, medication, and blood glucose levels,
- Stress and psychological adjustment,
- Family involvement and social support,

- Benefits, risks, and management options for improving glucose control, and
- Use of health care systems and community resources.

For coverage by Medicare, DSMT programs must incorporate the following:

- Be accredited as meeting quality standards by a CMS-approved national accreditation organization. Currently, CMS recognizes the American Diabetes Association (ADA), the American Association of Diabetes Educators (AADE), and the Indian Health Service (IHS) as approved national accreditation organizations. Programs without accreditation by a CMS-approved national accreditation organization are not covered.
- Provide services to eligible Medicare beneficiaries that are diagnosed with diabetes.
- Submit an accreditation certificate from the ADA, AADE, or IHS to the local Medicare Contractor's provider enrollment department.

For additional information on DSMT enrollment, see the Internet-Only Manual, Pub. 100-08, Chapter 10.

Coverage Information

Medicare provides coverage of DSMT services only if the treating physician or treating qualified non-physician practitioner managing the beneficiary's diabetic condition certifies that DSMT services are needed. The referring physician or qualified non-physician practitioner must maintain a plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if ordered. The order must also include a statement signed by the physician or qualified non-physician practitioner that the service is needed as well as the following information:

- The number of initial or follow-up hours ordered (the physician can order less than 10 hours, but cannot exceed 10 hours of training),
- The topics to be covered in training (initial training hours can be used to pay for the full initial training program or specific areas, such as nutrition or insulin training), and
- A determination if the beneficiary should receive individual or group training.

The provider of the service must maintain documentation that includes the original order from the physician and any special conditions noted by the physician. The plan of care must be reasonable and necessary and must be incorporated into the beneficiary's medical record.

When the training under the order is changed, the training order/referral must be signed by the physician or qualified non-physician practitioner treating the beneficiary and maintained in the beneficiary's file in the DSMT's program records.

Initial DSMT Training

The initial year for DSMT is the 12-month period following the initial date.

Medicare will cover **initial** training that meets the following conditions:

- Is furnished to a beneficiary who has not previously received initial or follow-up training billed under HCPCS codes G0108 or G0109,
- Is furnished within a continuous 12-month period,
- Does not exceed a total of 10 hours for the initial training (the 10 hours of training can be done in any combination of ½ hour increments and can spread over the 12-month period or less),

- With the exception of 1 hour of individual training, training is usually furnished in a group setting, which can contain patients other than Medicare beneficiaries, and
- The 1 hour of individual training may be used for any part of the training including insulin training.

Follow-Up DSMT Training

After receiving the initial training, Medicare covers **follow-up** training that meets the following conditions:

- Consists of no more than 2 hours of individual or group training for a beneficiary each year,
- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries,
- Follow-up training is furnished in increments of no less than ½ hour,
- The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic, and
- Follow-up training for subsequent years is based on a 12-month calendar year after the completion of the full 10 hours of initial training. However, if the beneficiary exhausts 10 hours in the initial year then the beneficiary would be eligible for follow-up training in the next calendar year. If the beneficiary does not exhaust 10 hours of initial training, he/she has 12 continuous months to exhaust initial training before the 2 hours of follow-up training are available.

Examples

Example #1: Beneficiary Exhausts 10 hours in the Initial Year (**12 continuous months**)

Beneficiary receives first service: **April 2007**

Beneficiary completes initial 10 hours DSMT training: **April 2008**

Beneficiary is eligible for follow-up training: **May 2008** (13th month begins the subsequent year)

Beneficiary completes follow-up training: **December 2008**

Beneficiary is eligible for next year follow-up training: **January 2009**

Example #2: Beneficiary Exhausts 10 hours Within the Initial Calendar Year

Beneficiary receives first service: **April 2007**

Beneficiary completes initial 10 hours of DSMT training: **December 2007**

Beneficiary is eligible for follow-up training: **January 2008**

Beneficiary completes follow-up training: **July 2008**

Beneficiary is eligible for next year follow-up training: **January 2009**

Individual DSMT Training

Medicare covers training on an individual basis for a Medicare beneficiary under any of the following conditions:

- No group session is available within two months of the date the training is ordered,
- The beneficiary's physician or qualified non-physician practitioner documents in the beneficiary's medical record that the beneficiary has special needs resulting from conditions, such as severe vision, hearing, or language limitations, or other such special conditions as identified by the treating physician or qualified non-physician practitioner, that will hinder effective participation in a group training session,

- The physician orders additional insulin training, or
- The need for individual training must be identified by the physician or qualified non-physician practitioner in the referral.

Coverage for DSMT services is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment apply.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 7 are used to report DSMT services:

Table 7 – HCPCS Codes for DSMT Services

HCPCS Code	Code Descriptor
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes **Note:** For FQHCs, codes representing group sessions do not constitute a separate billable visit.

Diagnosis Requirements

There are no specific diagnosis requirements for DSMT services. For further guidance, contact your Medicare Contractor.

Billing Requirements

General Information

All Medicare providers who may bill for other Medicare services or items, and who represent a DSMT program that is accredited as meeting quality standards, can bill and receive payment for the entire DSMT program.

Medicare providers cannot submit claims for DSMT services as "incident to" services. However, a physician advisor for a DSMT program is eligible to bill for the DSMT service for that program.

Medicare providers must bill for services for DSMT with the appropriate HCPCS code in 30-minute increments.

Also, the following conditions apply:

- A cover letter and National Provider Identifier (NPI) must be included with the accreditation certificate.
- The Medicare provider must have a provider and/or supplier number and the ability to bill Medicare for other services.

- Registered dietitians are eligible to bill on behalf of an entire DSMT program as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service.

DME suppliers are reimbursed through local carriers/AB MACs.

Claims from physicians, qualified non-physician practitioners, or suppliers who did not accept assignment are subject to Medicare's limiting charge. However, the following non-physician practitioners must accept assignment for all of their services: physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS code and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code, revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for DSMT services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 8:

Table 8 – Facility Types, Types of Bills, and Revenue Codes for DSMT Services

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B	12X	0942
Hospital Outpatient	13X	0942
Skilled Nursing Facility (SNF)*	22X, 23X	0942
Indian Health Service (IHS) provider billing hospital outpatient Part B	13X	0942
IHS provider billing hospital inpatient Part B	12X	0942
IHS Critical Access Hospital (CAH) billing outpatient Part B	85X	0942
IHS CAH billing inpatient Part B	12X	0942
Method I or Method II CAH (technical services)	12X, 85X	0942
Home Health Agency (HHA)	34X	0942
Federally Qualified Health Center (FQHC)**	73X	052X, 0900
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12X, 13X	0942

***NOTE:** The SNF consolidated billing provision allows separate Part B payment for training services for beneficiaries that are in skilled Part A SNF stays; however, the SNF must submit these services on a 22X bill type. Training services provided by other provider types must be reimbursed by the SNF.

****NOTE:** Effective January 1, 2006, payment for DSMT provided in an FQHC that meets all of the requirements as above, may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed on TOB 73X, with HCPCS codes G0108 or G0109, and revenue codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900.

NOTE: An End-Stage Renal Disease (ESRD) facility is a reasonable site for this service; however, because it is required to provide dietitian and nutritional services as part of the care covered in the composite rate, ESRD facilities are not allowed to bill for it separately and do not receive separate reimbursement. Likewise, an RHC is a reasonable site for this service; however, it must be provided in an RHC with other qualifying services and paid at the all-inclusive encounter rate.

NOTE: The Medicare provider's certification must be submitted along with the initial claim.

DSMT Coding Tips

The following tips are designed to facilitate proper billing when submitting claims for DSMT services:

- For an hour session, a "2" must be placed in the "Units" column, representing two 30-minute increments.
- Billing an Evaluation and Management (E/M) code is not mandatory before billing the DSMT procedure codes. Do not use E/M codes in lieu of HCPCS codes G0108 and G0109.
- The nutrition portion of the DSMT program must be billed using HCPCS codes G0108 and G0109. Do not use the Medical Nutrition Therapy CPT codes for the nutrition portion of a DSMT program.
- The DSMT and Medical Nutrition Therapy benefits can be provided to the same beneficiary in the same year. However, they are different benefits and require separate referrals from physicians or qualified non-physician practitioners. The medical evidence reviewed by CMS suggests that the Medical Nutrition Therapy benefit for diabetic patients is more effective if it is provided after completion of the initial DSMT benefit.
- Medicare pays for up to 10 hours of initial DSMT in a continuous 12-month period. Two hours of follow-up DSMT may be covered in subsequent years.

Certified Providers

DSMT is not a separately recognized provider type like a physician or nurse practitioner. A person or entity cannot enroll in Medicare for the sole purpose of performing DSMT. DSMT is an extra service that a currently-enrolled Medicare provider can bill for, assuming the provider meets all the necessary DSMT requirements.

The statute states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient DSMT services, provides other items and services for which payment may be made under Title XVIII of the Social Security Act, and meets certain quality standards. CMS designates all providers and suppliers that bill Medicare for other individual services such a hospital outpatient departments, renal dialysis facilities, physicians, and durable medical equipment suppliers as certified. A designated certified provider must bill for DSMT services provided by an accredited DSMT program.

Reimbursement Information

General Information

Reimbursement for DSMT services may be made to any certified provider or supplier that provides and bills Medicare for other individual items and services and may be made only for training sessions actually attended by the beneficiary and documented on attendance sheets.

Entities that may participate as RHCs or FQHCs may also choose to become accredited providers of DSMT services, if they meet all requirements of an accredited DSMT service provider.

The Medicare Part B deductible and coinsurance or copayment apply. Claims from physicians, qualified non-physician practitioners, or suppliers where assignment was not taken are subject to Medicare's limiting charge. However, the following non-physician practitioners must accept assignment for all of their services: physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.

- The beneficiary must meet the following condition if the provider is billing for initial training:
  - The beneficiary has not previously received initial or follow-up training for which Medicare payment was made under this benefit.

FQHCs and RHCs

- Previously, DSMT-type services rendered by qualified registered dietitians or nutrition professionals were considered "incident to" services under the FQHC benefit, if all relevant program requirements were met. Therefore, separate all-inclusive encounter rate payment could not be made for the provision of DSMT services. Effective January 1, 2006, FQHCs are eligible for a separate payment under Part B for these one-on-one, face-to-face encounter services provided they meet all program requirements. See Pub. 100-04, Chapter 18, Section 120. Medicare makes payment to FQHCs at the all-inclusive encounter rate. This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying DSMT services. To receive payment for DSMT services in addition to a separate payment for an otherwise qualifying FQHC visit when the other services are provided on the same date, the DSMT services must be billed on TOB 73X with HCPCS code G0108 and one of the following revenue codes: 0520, 0521, 0522, 0524, 0525, 0527, or 0528 as appropriate. (Note: For FQHCs, codes representing group sessions do not constitute a separate billable visit. Therefore, although services billed under G0109 can be provided, they cannot be separately paid outside of the single daily encounter rate.)
- FQHCs that are certified providers of DSMT services can receive per-visit payments for covered services rendered by registered dietitians or nutrition professionals. These services are included under the FQHC benefit as billable visits.
- While Medicare does not make separate payment for this service to RHCs, the service is covered but is considered included in the all-inclusive encounter rate. RHCs are permitted to become certified providers of DSMT services and report the cost of DSMT services on their cost report for inclusion in the computation of their all-inclusive payment rates. Note: The provision of these services by registered dietitians or nutrition professionals might be considered "incident to" services in the RHC setting, provided all applicable conditions are met. However, they do not constitute an RHC visit.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for DSMT services is paid under the Medicare Physician Fee Schedule (MPFS), when billed to the carrier/AB MAC.

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for DSMT services depends on the type of facility providing the service. Table 9 lists the type of payment that facilities receive for DSMT services:

Table 9 – Facility Payment Methodology for DSMT Services

If the Facility is a…	Then Payment Is Based On...
Method I or Method II Critical Access Hospital (CAH)	Reasonable Cost Basis (for technical services) **(Paid at 101% of their reasonable cost)**
Hospital subject to Outpatient Prospective Payment System (OPPS)	Medicare Physician Fee Schedule (MPFS)
Indian Health Service (IHS) provider billing hospital outpatient Part B	OMB-approved outpatient per visit all inclusive rate
IHS provider billing inpatient Part B	All-inclusive inpatient ancillary per diem rate
IHS CAH billing outpatient Part B	101% of the all-inclusive facility specific per visit rate
IHS CAH billing inpatient Part B	101% of the all-inclusive facility specific per diem rate
Skilled Nursing Facility (SNF)	MPFS non-facility rate
Federally Qualified Health Center (FQHC)*	All-Inclusive Encounter Rate (with other qualified services) Separate visit payment available with HCPCS Code G0108*
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	94% of provider submitted charges in accordance with the terms of the Maryland Waiver
Home Health Agency (HHA) (can be billed only if the service is provided outside of the treatment plan)	MPFS non-facility rate

***NOTE:** Effective January 1, 2006, payment for DSMT provided in an FQHC as a one-on-one face-to-face encounter may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed on TOB 73X, with HCPCS code G0108, and revenue codes 0520, 0521, 0522, 0524, 0525, 0527, or 0528.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of DSMT services:

- The beneficiary has exceeded the 10-hour limit of training,
- The physician or qualified non-physician practitioner did not order the training, or
- The individual furnishing the DSMT is not accredited by Medicare.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

The beneficiary is liable for services denied over the limited number of hours with referrals for DSMT. An ABN should be issued in these situations. In the absence of evidence of a valid ABN, the Medicare provider will be held liable. However, issuance of an ABN is not mandatory for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their State, but who have not obtained Medicare Provider Numbers. If the provider desires, the ABN may be issued as a voluntary exclusion from benefits.

For more information about the Advance Beneficiary Notice of Noncoverage (ABN), please refer to Reference Section G of this publication.

MEDICAL NUTRITION THERAPY (MNT)

Medicare provides coverage of medical nutrition therapy (MNT) for beneficiaries diagnosed with diabetes or renal disease (except for those receiving dialysis). More than 13.7 million Americans, at least 60 years or older, are diagnosed with diabetes or chronic kidney disease.[1] MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

The MNT benefit was established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). It became effective January 1, 2002. This benefit allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement.

The MNT benefit is a completely separate benefit from the Diabetes Self-Management Training (DSMT) benefit.

For the purpose of disease management, covered MNT services include the following:

- An initial nutrition and lifestyle assessment,
- Nutrition counseling,
- Information regarding diet management, and
- Follow-up sessions to monitor progress.

Diabetes and Renal Disease Defined

Diabetes Mellitus

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- A fasting blood glucose greater than or equal to 126 mg/dL on 2 different occasions.
- A 2-hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions.
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Renal Disease

For the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 36 months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [Glomerular Filtration Rate (GFR) 13-50 ml/min/1.73m^2].

Coverage Information

Medicare provides coverage of MNT services when the following general coverage conditions are met:

- The beneficiary has diabetes or renal disease.
- The treating physician must provide a referral and indicate a diagnosis of diabetes or renal disease. A treating physician means the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease (non-physician practitioners cannot make referrals for this service).
- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician.

1 Department of Health and Human Services. Centers for Disease Control and Prevention, "2007 National Diabetes Fact Sheet," accessed at: http://apps.nccd.cdc.gov/ddtstrs/FactSheet.aspx. The United States Renal Data System, "2008 USRDS Annual Data Report (ADR) Atlas," accessed at: http://www.usrds.org/2008/pdf/V1_Precis_2008.pdf.

- MNT services may be provided either on an individual or group basis without restrictions.
- MNT services must be provided by a registered dietitian, or nutrition professional who meets the provider qualification requirements, or a "grandfathered" dietitian or nutritionist who was licensed as of December 21, 2000. (See the Professional Standards for Dietitians and Nutrition Professionals section later in this chapter.)
- For a beneficiary with a diagnosis of diabetes, DSMT and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary.
- For the beneficiary with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the beneficiary may receive MNT services based on a change in medical condition, diagnosis, or treatment.

This benefit provides three hours of one-on-one MNT services for the first year and two hours of coverage each year for subsequent years. Based on medical necessity, additional hours may be covered if the treating physician orders additional hours of MNT based on a change in medical condition, diagnosis, or treatment regimen.

Medicare provides coverage of MNT as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies.

Limitations on Coverage

The following limitations apply:

- MNT services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under Section 1881 of the Social Security Act.
- A beneficiary may not receive MNT and DSMT services on the same day.

Referrals for MNT Services

Medicare provides coverage for three hours of MNT in the beneficiary's initial calendar year. No initial hours can be carried over to the next calendar year. For example, if a physician gives a referral to a beneficiary for three hours of MNT but a beneficiary only uses two hours in November, the calendar year ends in December and if the third hour is not used, it cannot be carried over into the following year. The following year, a beneficiary is eligible for two follow-up hours (with a physician referral). Every calendar year, a beneficiary must have a new referral for follow-up hours.

A referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease.

The referring physician must maintain documentation in the beneficiary's medical record. Referrals must be made for each episode of care and reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. The referring physician's provider number must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. The carrier/AB Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI)/AB MAC may return claims that do not contain the provider number of the referring physician.

NOTE: Medicare may cover additional covered hours of MNT services beyond the number of hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis or medical condition within an episode of care that makes a change in diet necessary.

A physician must prescribe these services and renew the referral yearly if continuing treatment is needed into another calendar year.

Telehealth

Effective January 1, 2006, Medicare expanded the list of telehealth services to include coverage for individual MNT as described by Healthcare Common Procedure Coding System (HCPCS) codes G0207, 97802, and 97803. In addition, certified registered dietitians and nutrition professionals have been added to the list of practitioners who may furnish and receive payment for a telehealth service.

This expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment, or billing methodology applicable to Medicare telehealth services, as set forth in the Medicare Benefit Policy Manual and the Medicare Claims Processing Manual. For example, originating sites must be located in either a non-Metropolitan Statistical Area (MSA) county or rural health professional shortage area, and can only include a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or federally qualified health center. Additionally, an interactive audio and video telecommunications system must be used that permits real-time communication between the distant site physician, or practitioner, and the Medicare beneficiary. As a condition of payment, the beneficiary must be present and participating in the telehealth visit. The only exception to this interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In these circumstances, Medicare payment is permitted for telehealth services when asynchronous store-and-forward technology is used.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes listed in Tables 10 and 11 to report MNT services:

Table 10 – HCPCS/CPT Codes for MNT Services

HCPCS/CPT Code	Code Descriptor
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes (**NOTE:** This CPT code must only be used for the initial visit.)

HCPCS/CPT Code	Code Descriptor
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

NOTE: For FQHCs, codes representing group sessions do not constitute a separate billable visit.

Table 11 – Instructions for Use of the MNT Codes

HCPCS/CPT Code	Instructions for Use
G0270 & G0271	These codes are to be used when additional hours of MNT services are performed beyond the number of hours typically covered when the treating physician determines there is a chance of diagnosis or medical condition that makes a change in diet necessary.
97802	This code is to be used once a year, for initial assessment of a new patient. All subsequent individual visits (including reassessments and interventions) are to be coded as 97803. All subsequent Group Visits are to be billed as 97804.
97803	This code is to be billed for all individual reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient.
97804	This code is to be billed for all group visits, initial and subsequent. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group.

NOTE: For FQHCs, codes representing group sessions do not constitute a separate billable visit.

NOTE: Medicare will make payment for the above codes only if a registered dietitian or nutrition professional who meets the specified requirements under Medicare submits the claim. These services cannot be paid "incident to" physician services. The payments can be reassigned to the employer of a qualifying dietitian or nutrition professional.

NOTE: **Telehealth services:** Effective January 1, 2006, the telehealth modifiers "GT" (via interactive audio and video telecommunications system) and "GQ" (via synchronous telecommunications system) are valid when billed with HCPCS codes G0270, 97802, and 97803.

Diagnosis Requirements

MNT services are available for beneficiaries with diabetes or renal disease. The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease. For further guidance, contact your Medicare Contractor.

MNT and DSMT
Separate Billable Services

The MNT and DSMT benefits can be provided to the same beneficiary in the same year but **may not** be provided on the same day. They are different benefits and require separate referrals from physicians.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT code and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Special Requirement Note: Registered dietitians and nutrition professionals can be part of a group practice in which case the provider identification number of the registered dietitian or nutrition professional that performed the service must be entered on the claim form.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, the Medicare provider must report the appropriate HCPCS/CPT code, the appropriate revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Special Requirement Note: MNT services can be billed to FIs/AB MACs when performed in an outpatient hospital setting. Hospital outpatient departments can bill for MNT services through the local FI/AB MAC if the registered dietitians or nutrition professionals reassign their benefits to the hospital. If the hospitals do not get the reassignments, the registered dietitians and nutrition professionals will have to bill the local carrier/AB MAC under their own provider number or the hospital will have to bill the local carrier/AB MAC. Registered dietitians and nutrition professionals must obtain a Medicare provider number before they can reassign their benefits.

Professional Standards for Dietitians and Nutrition Professionals

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means an individual who, on or after December 22, 2000:

- Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose;
- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual; and
- Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements stated above.

OR

- A "grandfathered" dietitian or nutritionist licensed or certified in a State as of December 21, 2000 is not required to meet the requirements above.
- A registered dietitian in good standing, as recognized by the Commission of Dietetic Registration or its successor organization, is deemed to have met the requirements above.

Enrollment of Dietitians and Nutrition Professionals

The following qualifications must be met for the enrollment of dietitians and nutrition professionals:

- In order to file claims for MNT, a registered dietitian/nutrition professional must be enrolled as a Medicare provider and meet the requirements outlined above. MNT services can be billed with the effective date of the Medicare provider's license and the establishment of the practice location.
- The Medicare carrier/AB MAC will enroll registered dietitians and nutritional professionals as a provider of MNT services using the NPI.
- Registered dietitians and nutrition professionals must accept assignment and the limiting charge will not apply.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for MNT services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 12:

Table 12 – Facility Types, Types of Bills, and Revenue Codes for MNT Services

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	0942
Skilled Nursing Facility Outpatient (SNF)	23X	0942

Facility Type	Type of Bill	Revenue Code
Home Health Agency (HHA) (Not under an HHA plan of care)	34X	0942
Critical Access Hospital (CAH)	85X	0942

NOTE: Separate payment to RHCs (TOB 71X) is precluded as these services are not within the scope of the Medicare-covered RHC benefits. However, FQHCs (TOB 73X) may qualify for a separate visit for payment for MNT services in addition to any other qualifying visit on the same date of service as long as the services provided were individual services and billed with the appropriate site of service revenue code in the 052X series. Group services do not meet the criteria for a separate qualifying encounter.

Reimbursement Information

Reimbursement for outpatient MNT is based on rates established under the Medicare Physician Fee Schedule (MPFS) for bill types 13X, 23X, and 34X. Payment is the lesser of the actual charge or 85 percent of the MPFS. The Medicare Part B deductible and coinsurance or copayment apply. Coinsurance is based on 20 percent of the lesser charge. For Critical Access Hospitals (CAHs), bill type 85X, payment is made based on reasonable charges and is not subject to the lesser of costs or charges. For CAHs, if the distant site is a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to this CAH, the CAH should bill its regular FI/AB MAC for the professional telehealth services provided, using revenue codes 096X, 097X or 098X. In addition, all requirements for billing distant site telehealth services apply.

- Payment is made for MNT services attended by the beneficiary and documented by the Medicare provider.
- Payment is made for beneficiaries that are not inpatients of a hospital, SNF, hospice, or nursing home.

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Entities that may participate as RHCs or FQHCs may also choose to become accredited providers of MNT services. The cost of such services can be bundled into their clinic/center payment rates. However, RHCs and FQHCs must meet all coverage requirements and services must be provided by a registered dietitian or nutrition professional. In addition, the medical evidence reviewed by CMS suggests that the MNT benefit for diabetic patients is more effective if it is provided after completion of the initial DSMT benefit.

While Medicare does not make separate payment for this service to RHCs, similar services may be covered when furnished by, or incident to, an RHC professional. Payment is included in the encounter rate when coverable.

FQHCs that are certified providers of MNT services can receive per-visit payments for covered services rendered by registered dieticians or nutrition professionals. These services are included under the FQHC benefit as billable visits.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of MNT services:

- The beneficiary is not qualified to receive this benefit.
- The individual provider of the MNT services did not meet the provider qualification requirements.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements for MNT

The beneficiary is liable for services denied over the limited number of hours with referrals for MNT. An ABN should be issued in these situations. An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their state but who have not obtained Medicare provider numbers.

For more information about the Advance Beneficiary Notice of Noncoverage (ABN), please refer to Reference Section G of this publication.

OTHER DIABETES SERVICES

Medicare provides coverage of the following services for beneficiaries with diabetes:

- Foot Care;
- Hemoglobin A1c tests;
- Glaucoma Screening;
- Influenza and pneumococcal immunizations;
- Routine costs, including immunosuppressive drugs, cell transplantation, and related items and services for pancreatic islet cell transplant clinical trials; and
- Retinal eye exams for diabetic retinopathy.*

NOTE:

- Details regarding Medicare's coverage of glaucoma screening services and influenza and pneumococcal vaccinations are described in this Guide. For specific information regarding other diabetes services, refer to relevant CMS documentation.
- *Retinal eye exams for diabetic retinopathy may be covered as a medically necessary diagnostic exam furnished to beneficiaries diagnosed with diabetes.

Diabetes Supplies and Services Not Covered by Medicare

Medicare Part B may not cover all supplies and equipment for beneficiaries with diabetes. The following may be excluded:

- Insulin pens
- Insulin (unless used with an insulin pump)
- Syringes
- Alcohol swabs
- Gauze
- Orthopedic shoes (shoes for individuals whose feet are impaired, but intact)
- Eye exams for glasses (refraction)
- Weight loss programs
- Injection devices (jet injectors)

Note: Insulin not used with an external insulin pump and certain medical supplies used to inject insulin are covered under Medicare prescription drug coverage.

For more information on coverage exclusions, contact your local Medicare Contractor.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Special Rules for Medicare Competitive Bidding Areas

If a competitively bid item is provided by a non-contract supplier in a competitive bidding area (CBA), Medicare will not pay for the item unless the non-contract supplier meets the definition of a grandfathered supplier. Grandfathered supplier means a non-contract supplier that chooses to continue to furnish competitively bid items for which payment is made on a rental basis to beneficiaries who maintain a permanent residence in the CBA. If the non-contract supplier furnishes the item to a beneficiary and does not meet the grandfathering provision, the beneficiary is not liable for payment.

If the non-contract supplier obtains a signed Advance Beneficiary Notice of Noncoverage (ABN) indicating that the beneficiary was informed in writing prior to receiving the item or service that there would be no coverage due to the supplier's non-contract status, and the beneficiary understands that he/she will be liable for all costs because of the decision to use a non-contract supplier, the non-contract supplier may charge the beneficiary for the item or service. In this instance, non-contract suppliers cannot bill Medicare and receive payment for the item or service.

For further information on the competitive bidding program, contact the Competitive Bidding Program helpline at 877-577-5331 or visit http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home or http://www.cms.hhs.gov/dmeposcompetitivebid on the Web.

For more information about the Advance Beneficiary Notice of Noncoverage (ABN), please refer to Reference Section G of this publication.

Diabetes Screening Tests, Supplies, Self-Management Training, Medical Nutrition Therapy, and Other Services

Resource Materials

American Diabetes Association
Information on diabetes prevention, nutrition, research, etc. is available in both English and Spanish.
http://www.diabetes.org

American Diabetes Association's Diabetes Pro Professional Resources Online Website
http://professional.diabetes.org/

American Dietetic Association
Website provides food and nutrition information and a national referral service to locate registered nutrition practitioners.
http://www.eatright.org

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Clinical Laboratory Fee Schedule Information
http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Final Rule, 42 C.F.R. Parts 409, 410, et al.; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer generated Facsimile Transmissions
http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1204957&intNumPerPage=10

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Indian Health Services Division of Diabetes Treatment and Prevention
http://www.ihs.gov/MedicalPrograms/Diabetes/index.asp

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule.
http://www.cms.hhs.gov/center/provider.asp

Beneficiary-related resources can be found in Reference F of this Guide.

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

National Diabetes Information Clearinghouse – NDIC
Information on diabetes treatment and statistics is available in both English and Spanish.
http://diabetes.niddk.nih.gov

National Diabetes Statistics
http://diabetes.niddk.nih.gov/dm/pubs/statistics/index.htm

National Provider Identifier Information
http://www.cms.hhs.gov/NationalProvIdentStand

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Diabetes Screening

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 90
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

DSMT

MLN Matters Article 5433, Guidelines for Payment of Diabetes Self-Management Training (DSMT)
http://www.cms.hhs.gov/MLNMattersArticles/Downloads/mm5433.pdf

Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 300
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

Beneficiary-related resources can be found in Reference F of this Guide.

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 120
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

MNT

Medicare Claims Processing Manual – Pub. 100-04, Chapter 4, Section 300
http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Notes

Screening Mammography

Overview

Breast cancer is the most frequently diagnosed non-skin cancer in women, and is second only to lung cancer as the leading cause of cancer-related deaths among women in the United States. Every woman is at risk, and this risk increases with age. Breast cancer also occurs in men; however, the number of new cases is few.[1]

Although breast cancer incidence (all ages) is slightly higher in Caucasian women than in African-American women, African-American women have a higher mortality rate and higher proportion of disease diagnosed at the advanced stage with larger tumor sizes. Fortunately, if diagnosed and treated early, the number of women who die from breast cancer can be reduced. The screening mammography benefit covered by Medicare can provide earlier detection, resulting in more prompt treatment of breast cancer.

Medicare's coverage of screening mammograms was created as a result of the implementation of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). This act authorized Medicare to begin covering screening mammograms on or after January 1, 1991. The Balanced Budget Act of 1997 (BBA) revised the statutory frequency parameters and age limitations Medicare uses to cover screening mammograms. The Benefits Improvement and Protection Act of 2000 (BIPA) provided for payment for the use of Computer-Aided Detection (CAD) technology in connection with the performance of a covered mammogram.

Mammography can be categorized as either a "screening mammogram" or a "diagnostic mammogram."

Screening Mammography

A screening mammogram is a radiologic procedure, an x-ray of the breast, used for the early detection of breast cancer in women who have no signs or symptoms of the disease and includes a physician's interpretation of the results. Unlike a diagnostic mammogram, there do not need to be signs, symptoms, or a history of breast disease in order for Medicare to cover the exam. It usually involves two x-rays of each breast. Mammograms make it possible to detect tumors that cannot be felt. Mammograms can also find microcalcifications (tiny deposits of calcium in the breast) that sometimes indicate the presence of breast cancer.

1 The National Cancer Institute. Rev. 2008. Breast Cancer (PDQ®) Prevention [online]. Bethesda, MD: The National Cancer Institute, The National Institutes of Health, The U.S. Department of Health and Human Services, 2008 [cited 20 November 2008]. Available from the World Wide Web: (http://www.cancer.gov/cancertopics/wyntk/breast).

Diagnostic Mammography

A diagnostic mammogram is an x-ray of the breast that is used to check for breast cancer after a lump or other sign or symptom of breast cancer has been found. Signs of breast cancer may include pain, skin thickening, nipple discharge, or a change in breast size or shape. A diagnostic mammogram may also be used to evaluate changes found during a screening mammogram, or to view breast tissue when it is difficult to obtain a screening mammogram because of special circumstances, such as the presence of breast implants.

A diagnostic mammogram is a diagnostic test covered by Medicare under the following conditions:

- An individual has distinct signs and symptoms for which a mammogram is indicated;
- An individual has a history of breast cancer; or
- An individual is asymptomatic, but based on the individual's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.

Risk Factors

A female beneficiary may be at high risk for developing breast cancer in the following situations:

- She has a personal history of breast cancer;
- She has a family history of breast cancer;
- She had her first baby after age 30; or
- She has never had a baby.

Coverage Information

Medicare provides coverage of a breast cancer screening mammogram annually (i.e., at least 11 full months have passed following the month in which the last Medicare screening mammogram was covered) for all female beneficiaries age 40 or older. Medicare also provides coverage of one baseline mammogram for female beneficiaries between the ages of 35 and 39.

Coverage for Screening Mammography Services

- Under age 35: No payment allowed
- Age 35 – 39: Baseline (only one screening allowed for women in this age group)
- Over age 39: Annual (11 full months have elapsed following the month of last screening)

Medicare provides coverage for breast cancer screening mammography as a Medicare Part B benefit. The coinsurance or copayment applies. There is no Medicare Part B deductible for this benefit. A physician's prescription or referral is not necessary for a screening mammogram to be covered by Medicare. Medicare determines whether or not to make payment for this based on a woman's age and statutory frequency parameters.

Medicare also covers digital technologies for mammogram screenings. The coinsurance or copayment applies. There is no Medicare Part B deductible for this benefit.

NOTE: A "diagnostic mammogram" requires a prescription or referral by a physician or qualified non-physician practitioner (i.e., clinical nurse specialist, nurse midwife, nurse practitioner, or physician assistant) to be covered.

NOTE: Mammography services must be provided in a Food and Drug Administration (FDA) or a State/Mammography Quality Standards Act (MQSA) certified radiological facility and a qualified physician, who is directly associated with the facility at which the mammogram was taken, must interpret the results.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes listed in Table 1 to report mammography services:

Table 1 – HCPCS/CPT Codes for Mammography Services

HCPCS/CPT Code	Code Descriptor
77051	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure) (Use 77051 in conjunction with 77055, 77056)
77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure) (Use 77052 in conjunction with 77057)
77055	Mammography; unilateral (Use 77055 in conjunction with 77051 for computer-aided detection applied to a diagnostic mammogram)
77056	Mammogram; bilateral (Use 77056 in conjunction with 77051 for computer-aided detection applied to a diagnostic mammogram)
77057	Screening mammography, bilateral (2-view film study of each breast) (Use 77057 in conjunction with 77052 for computer-aided detection applied to a screening mammogram) (For electrical impedance breast scan, use 76499)
G0202	Screening mammography, producing direct digital image, bilateral, all views
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views

Diagnosis Requirements

The Balanced Budget Act of 1997 (BBA) eliminated payment based on high risk indicators. However, to ensure proper coding, Medicare providers must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes listed in Table 2 on screening mammography claims as appropriate:

Table 2 – Diagnosis Codes for Screening Mammography Services

ICD-9-CM Diagnosis Code	Code Descriptor
V76.11	Special screening for malignant neoplasm, screening mammogram for high-risk patient
V76.12	Special screening for malignant neoplasm, other screening mammography

Diagnosis codes for diagnostic mammography will vary according to the diagnosis.

Need for Additional Films

Medicare allows additional films to be taken without an order from the treating physician. In such situations, a radiologist who interprets a screening mammogram is allowed to order and interpret additional diagnostic films based on the results of the screening mammogram while the beneficiary is still at the facility for the screening exam.

Billing Requirements

General Information

Mammography services may be billed by the following three categories:

- **Technical Component (TC)** – services rendered outside the scope of the physician's interpretation of the results of an examination.
- **Professional Component (PC)** – physician's interpretation of the results of an examination.
- **Global Component** – encompasses both the technical and professional components.

Global billing is not permitted for services furnished in an outpatient facility. Critical Access Hospitals (CAHs) may not use global HCPCS codes as the TC and PC components are paid under different methodologies.

When submitting a claim for a screening mammogram and a diagnostic mammogram for the same beneficiary on the same day, the Medicare provider must attach

Coding Tips

Even though Medicare does not require a physician's order or referral for payment of a screening mammogram, physicians who routinely write orders or referrals for mammograms should clearly indicate the type of mammogram (screening or diagnostic) the beneficiary is to receive. The order should also include the applicable ICD-9-CM diagnosis code that reflects the reason for the test and the date of the last screening mammography. This information will be reviewed by the radiologist, who can ensure that the beneficiary receives the correct service.

Computer-Aided Detection (CAD) payment is built into the payment of the digital mammography services. Therefore, CAD is billable as a separately identifiable add-on code that must be performed in conjunction with a base mammography code. CAD can be billed in conjunction with both standard film and direct digital image screening and diagnostic mammography services.

modifier GG to the diagnostic mammogram (CPT codes 77055 and 77056 or HCPCS codes G0204 or G0206). Medicare requires that modifier GG be appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Medicare will reimburse for both the screening mammogram and the diagnostic mammogram.

Payment for the Computer-Aided Detection (CAD) mammography (CPT codes 77051 and 77052) cannot be made if billed alone. If the beneficiary receives CAD mammography as part of a Medicare screening or diagnostic mammography service, the CAD codes must be billed in conjunction with primary service codes (Table 1).

Effective October 1, 1994, all facilities providing screening and diagnostic mammography services must have a certificate issued by the Food and Drug Administration (FDA) in order to be reimbursed by Medicare. The appropriate FDA certification number must be included on claims submitted to the carrier/AB Medicare Administrative Contractor (AB MAC) on the CMS-1500 claim form (or the electronic equivalent 837-P) for the film and/or digital mammography service. Note that this number should not be included on claims submitted to the FI/AB MAC.

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT code and the corresponding diagnosis code on the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

NOTE: Based on provisions in the NPI Final Rule published in January 2004, effective December 1, 2008, when a provider bills for a mammography screening or diagnostic service that has been purchased from a provider located in another Medicare Contractor's jurisdiction, the billing provider must, in addition to reporting its own NPI on a paper or electronically-submitted Medicare claim (as the billing provider), also report its own NPI as the performing provider, and annotate the claim with the name, address, and ZIP code of the performing provider.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT code, the appropriate revenue code, and the corresponding diagnosis code on the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

NOTE: In the past, institutional providers used a surrogate unique physician identification number (UPIN) "SLF000" in the Attending Physician UPIN field on Form CMS-1450. Based on provisions in the NPI Final Rule published in January 2004, effective May 23, 2008, institutional providers submitting claims for self-referred mammography services are to duplicate the institution's own NPI (not UPIN) in the attending physician NPI field on claims. Suppliers submitting claims for self-referred mammography services are to duplicate the supplier's own NPI in the attending/referring physician NPI field on their claims.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for mammography services when submitted on the following Types of Bills (TOBs) listed in Table 3:

Table 3 – Facility Types, Types of Bills, and Revenue Codes for Mammography Services

Facility Type	Mammography Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	For screening mammography	12X	0403
Hospital Inpatient Part B including CAH	For diagnostic mammography	12X	0401
Hospital Outpatient	For screening mammography	13X	0403
Hospital Outpatient	For diagnostic mammography	13X	0401
Skilled Nursing Facility (SNF) Inpatient Part B	For screening mammography	22X	0403
SNF Inpatient Part B	For diagnostic mammography	22X	0401
SNF Outpatient	For screening mammography	23X	0403
SNF Outpatient	For diagnostic mammography	23X	0401

Facility Type	Mammography Type	Type of Bill	Revenue Code
Rural Health Clinic (RHC)	For screening mammography	71X	052X (see following additional instructions)
RHC	For diagnostic mammography	71X	052X (see following additional instructions)
Federally Qualified Health Center (FQHC)	For screening mammography	73X	052X (see following additional instructions)
FQHC	For diagnostic mammography	73X	052X (see following additional instructions)
CAH*	For screening mammography	85X	0403, 096X, 097X, 098X
CAH*	For diagnostic mammography	85X	0401, 096X, 097X, 098X

***NOTE:** Method I – All technical components are paid using standard institutional billing practices.

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X.

NOTE: For further instructions, see Section 20 of Chapter 18 of Pub. 100-04, Medicare Claims Processing Manual, at http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf on the CMS website.

NOTE: Effective April 1, 2005, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter 052X or 0900.

NOTE: Each FI/AB MAC may choose to accept other bill types for the technical component of the screening mammogram. If the Medicare provider would like to bill using a different bill type, the Medicare provider must contact the local FI/AB MAC to determine if a particular bill type is allowed.

Additional Billing Instructions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

RHCs and FQHCs should follow these additional billing instructions to ensure that proper payment is made for services and to allow the Common Working File (CWF) to perform age and frequency editing.

- **Technical Component** for Provider-Based RHCs and FQHCs:
  - For a screening or diagnostic mammography, the base provider must bill the FI/AB MAC under bill type 12X, 13X, 22X, 23X, or 85X, as appropriate using the base provider's NPI number following the billing instructions applicable to the base provider. Do not use the RHC/FQHC provider number since these services are not covered as RHC/FQHC services.
- **Technical Component** for Independent RHCs and FQHCs:
  - For a screening or diagnostic mammography, the individual practitioner must bill the carrier/AB MAC under their own NPI number following the instructions for billing the carrier/AB MAC. Do not bill the FI/AB MAC or use the RHC/FQHC NPI number since these services are not covered as RHC/FQHC services.
- **Professional Component** for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a screening or diagnostic mammography is furnished within an RHC/FQHC by a physician or qualified non-physician, the mammography is considered an RHC/FQHC service. The RHC/FQHC must bill the FI/AB MAC under bill type 71X or 73X respectively for an encounter. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 to report the related visit.

Reimbursement Information

General Information

As a result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, effective for claims with dates of service on or after January 1, 2005, Medicare will pay for diagnostic mammography and CAD services based on the Medicare Physician Fee Schedule (MPFS). Payment will no longer be made under the Outpatient Prospective Payment System (OPPS).

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

The coinsurance or copayment applies for the screening mammography service. There is no Medicare Part B deductible for the screening mammography service.

The Medicare Part B deductible and coinsurance or copayment apply for diagnostic mammography.

Reimbursement for mammography services is issued for the technical and professional components of the mammography when furnished by separate physicians/suppliers. Medicare providers furnishing both components are paid the global fee, except for Method II CAHs.

Reimbursement for CAD mammography codes 77051 and 77052 cannot be made if billed alone. They must be billed in conjunction with the primary service codes (Table 1).

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for mammography services is the lower of the actual charge or the MPFS amount for the service billed.

> See the National Correct Coding Initiative Edits web page for currently applicable bundled carrier processed procedures at http://www.cms.hhs.gov/NationalCorrectCodInitEd on the CMS website.

Payment Requirements for Non-Participating Physicians

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all mammography tests (screening and diagnostic).

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for mammography services is the lower of the actual charge or the MPFS amount for the service billed with the exception of CAHs, RHCs, and FQHCs (Table 4).

Table 4 – Types of Payments Received for Mammography Services Furnished by Facilities

Provider of Service	Form of Payment
CAH	Reasonable Cost Basis (See following options)
FQHC	All-inclusive rate for the professional component (codes 77055, 77056, and 77057)
Hospital Outpatient Department	Medicare Physician Fee Schedule (MPFS)
RHC	All-inclusive rate for the professional component (codes 77055, 77056, and 77057)
SNF	MPFS

Critical Access Hospital (CAH) Payment

Medicare makes payment for CAHs using the guidelines listed below. CAHs must not use modifiers TC or -26. The technical component (TC) versus the professional component (PC) is determined by the revenue code the provider uses.

Method I CAHs

Payment for the TC for a diagnostic mammography provided in Method I CAHs is based on 101 percent of reasonable cost. For a diagnostic mammography, Medicare makes payment under revenue code 0401. Medicare pays for the TC of a screening mammography using the non-facility MPFS rate under revenue code 0403. For a screening mammography use the following HCPCS codes: G0202, 77057, or 77052. For a diagnostic mammography use the following HCPCS codes: G0204, G0206, 77055, 77056, or 77051.

Method II CAHs

Medicare pays for the TC of a screening mammography based on the non-facility MPFS rate and pays for the PC based on the facility MPFS rate.

Method II CAHs must submit claims for the TC of a screening mammography using revenue code 0403 and the following HCPCS codes: G0202, 77057, or 77052. Medicare pays for the TC at 80 percent of the non-facility rate on the MPFS.

Method II CAHs must submit claims for the PC of a screening mammography using one of the following revenue codes: 096X, 097X, or 098X. The CAH may also use any of the following HCPCS codes: G0202, 77057, or 77052. Medicare pays the PC for these claims at 115 percent of the facility rate on the MPFS.

Medicare pays for the TC of a diagnostic mammography at 101 percent of reasonable cost. For the PC of a diagnostic mammography, Medicare makes payment based on 115 percent of the facility rate on the MPFS.

Method II CAHs must submit claims for the TC of a diagnostic mammography using revenue code 0401 and the following HCPCS codes: G0204, G0206, 77055, 77056, or 77051.

Method II CAHs must submit claims for the PC of a diagnostic mammography using one of the following revenue codes: 096X, 097X, or 098X. The CAH may also use any of the following HCPCS codes: G0204, G0206, 77055, 77056, or 77051.

Skilled Nursing Facility (SNF) Payment

A SNF can provide both screening and diagnostic mammography services. Comprehensive SNF mammography payment information and tables are available in the Medicare Claims Processing Manual, Chapter 18, Section 20.3.2.4, at http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf on the CMS website.

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of mammography screening tests:

- The beneficiary is not at least age 35.
- The beneficiary has received a covered screening mammogram during the past year.
- The beneficiary received a screening mammogram from a non-FDA or a non-State/MQSA-certified mammography provider.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Screening Mammography

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Breast Cancer (PDQ®): Prevention
A guide to breast cancer prevention produced by the National Cancer Institute.
http://www.cancer.gov/cancertopics/pdq/prevention/breast/Patient/page2

Breast Cancer Facts & Figures 2008
A comprehensive resource including many breast cancer statistics produced by the American Cancer Society.
http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 280.3
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

Medicare Claims Processing Manual
http://www.cms.hhs.gov/manuals

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 20
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

Beneficiary-related resources can be found in Reference F of this Guide.

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

National Provider Identifier Information
http://www.cms.hhs.gov/NationalProvIdentStand

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

What Are the Key Statistics For Breast Cancer?
This site provides a breast cancer fact sheet produced by the American Cancer Society.
http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_breast_cancer_5.asp?sitearea=

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Notes

Screening Pap Tests

Overview

The screening Pap test (Pap smear) covered by Medicare is a laboratory test that consists of a routine exfoliative cytology test (Papanicolaou test) provided for the purpose of early detection of cervical cancer. It includes collection of a sample of cervical cells and a physician's interpretation of the test.

A cervical screening detects significant abnormal cell changes that may arise before cancer develops; therefore, if diagnosed and treated early, any abnormal cell changes that may occur over time can be reduced or prevented. The cervical screening benefit covered by Medicare can aid in reducing illness and death associated with abnormal cell changes that may lead to cervical cancer.

Medicare's coverage of the screening Pap test was created as a result of the implementation of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989). This Act authorized Medicare to begin covering screening Pap tests provided to female beneficiaries on or after July 1, 1990.

Risk Factors

High risk factors for cervical and vaginal cancer include the following:

- Early onset of sexual activity (under 16 years of age),
- Multiple sexual partners (5 or more in a lifetime),
- History of a sexually transmitted disease [including human papillomavirus (HPV) and/or Human Immunodeficiency Virus (HIV) infection],
- Fewer than 3 negative Pap tests or no Pap test within the previous 7 years, and
- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

Coverage Information

Medicare provides coverage of a screening Pap test for all female beneficiaries. A doctor of medicine or osteopathy or other authorized practitioner (i.e., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist), who is authorized under State law to perform the examination must order and collect the screening Pap test. Frequency of coverage is provided as follows:

Covered once every 12 months:

Medicare provides coverage of a screening Pap test annually (i.e., at least 11 months have passed following the month in which the last Medicare-covered Pap test was performed) for female beneficiaries who meet **one** of the following criteria:

- There is evidence (on the basis of her medical history or other findings) that the woman is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years, or
- There is evidence that the woman is in one of the high risk categories (previously identified) for developing cervical or vaginal cancer, or has other specified personal history presenting hazards to health.

Covered once every 24 months:

- Medicare provides coverage of a screening Pap test for all asymptomatic non-high risk female beneficiaries every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening Pap test was performed).

NOTE: The term "woman of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings.

Medicare provides coverage for a Pap test as a Medicare Part B benefit. The coinsurance or copayment applies for the Pap test collection; however, there is no Medicare Part B deductible for Pap test collection. The beneficiary will pay nothing for the Pap laboratory test (there is no deductible and no coinsurance or copayment for the Pap laboratory test).

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1 to report screening Pap tests. Code selection depends on the reason for performing the test, the methods of specimen preparation and evaluation, and the reporting system used.

Table 1 – HCPCS Codes for Screening Pap Tests

HCPCS Code	Code Descriptor
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision
G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system under physician supervision
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision
G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision
G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening
P3000	Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision

Medicare providers must use the following HCPCS codes listed in Table 2 to report the physician's interpretation of screening Pap tests. Code selection depends on the reason for performing the test, the methods of specimen preparation and evaluation, and the reporting system used.

Table 2 – HCPCS Codes for Physician's Interpretation of Screening Pap Tests

HCPCS Code	Code Descriptor
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician
P3001	Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician

Medicare providers must use the following HCPCS code listed in Table 3 to report when the physician obtains, prepares, conveys the test, and sends the specimen to a laboratory.

Table 3 – HCPCS Code for Laboratory Specimen of Pap Tests

HCPCS Code	Code Descriptor
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Diagnosis Requirements

When a Medicare provider files a claim for a screening Pap test, one of the screening ("V") diagnosis codes listed in Tables 4 and 5 must be used. Code selection depends on whether the beneficiary is classified as low risk or high risk. The provider must report this diagnosis code, along with other applicable diagnosis codes. Failure to report the V72.31, V76.2, V76.47, V76.49, or V15.89 diagnosis code will result in denial of the claim.

Table 4 – Diagnosis Codes for Low Risk Screening Pap Tests

Low-Risk ICD-9-CM Diagnosis Code	Code Descriptor
V72.31	Routine Gynecological Examination **NOTE:** This diagnosis should only be used when the provider performs a full gynecological examination.
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasms, vagina

Low-Risk ICD-9-CM Diagnosis Code	Code Descriptor
V76.49	Special screening for malignant neoplasms, other sites **NOTE:** Providers use this diagnosis for women without a cervix.

Table 5 – Diagnosis Code for High Risk Screening Pap Tests

High-Risk ICD-9-CM Diagnosis Code	Code Descriptor
V15.89	Other

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians or qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS code and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Screening Pap test services may be billed to an FI/AB MAC by the technical component category, which is defined as services rendered outside the scope of the physician's interpretation of the results of an examination, or the professional component category, which is defined as a physician's interpretation of the results of an examination.

When submitting claims to FIs/AB MACs, the Medicare provider must report the appropriate HCPCS code, the appropriate revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for screening Pap tests when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 6:

Table 6 – Facility Types, Types of Bills, and Revenue Codes for Screening Pap Tests

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X	0311
Hospital Outpatient	13X	0311
Hospital Non-patient Laboratory Specimens including CAH	14X	030X
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0311
SNF Outpatient	23X	0311
CAH	85X	0311
Rural Health Clinic (RHC)	See Additional Billing Instructions below for RHCs.	
Federally Qualified Health Center (FQHC)	See Additional Billing Instructions below for FQHCs.	

NOTE: Revenue code 0923 must be used for billing code Q0091 (Table 3).

NOTE: CAHs electing Method II report professional services under revenue codes 096X, 097X, or 098X in addition to reporting the technical component.

Each FI/AB MAC may choose to accept other bill types for the technical component of the screening Pap test. If a provider would like to bill using a different bill type, the provider must contact the FI/AB MAC to determine if the particular bill type is allowed.

Additional Billing Instructions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

RHCs and FQHCs must follow these additional billing instructions to ensure that proper payment is made for services and to allow the Common Working File (CWF) to perform age and frequency editing.

There are specific billing and coding requirements for the technical component when a screening Pap test is furnished in an RHC or a FQHC. The technical component is defined as services rendered outside the scope of the physician's interpretation of the results of an examination.

Coding Tip

A screening Pap test and a screening pelvic examination can be performed during the same encounter. When this happens, both procedure codes should be shown as separate line items on the claim. Please see Additional Billing Instructions for RHCs and FQHCs.

Technical Component for Provider-Based RHCs and FQHCs:

For a screening Pap test, the base provider must bill the FI/AB MAC under bill type 13X, 14X, 22X, 23X, or 85X, as appropriate, using the base provider's ID number following the billing instructions applicable to the base provider. Do not use the RHC/FQHC provider ID number since these services are not covered as RHC/FQHC services.

Technical Component for Independent RHCs and FQHCs:

For a screening Pap test, the provider of the service must bill the carrier/AB MAC under their practitioner ID number following the instructions for billing the carrier/AB MAC. Do not use the RHC/FQHC provider ID number since these services are not covered as RHC/FQHC services.

Professional Component for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:

When a screening Pap test is furnished within an RHC/FQHC by a physician or qualified non-physician, the screening Pap test is considered an RHC/FQHC service. RHCs/FQHCs will use revenue code 052X to report the related visit. The provider (RHC/FQHC) of a screening Pap test must bill the FI/AB MAC under bill type 71X or 73X respectively.

NOTE: Independent RHCs and Freestanding FQHCs are freestanding practices that are not part of a hospital, Skilled Nursing Facility (SNF), or Home Health Agency (HHA). Provider-based RHCs and FQHCs are integral and subordinate parts of hospitals, SNFs, or HHAs, and under common licensure, governance, and professional supervision.

Reimbursement Information

General Information

Medicare provides coverage for the screening Pap test as a Medicare Part B benefit. The Medicare Part B deductible for screening Pap tests and services paid for under the Medicare Physician Fee Schedule does not apply. The coinsurance and deductible do not apply for the laboratory Pap test.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare bases reimbursement for screening Pap test services on the Clinical Laboratory Fee Schedule or the Medicare Physician Fee Schedule (MPFS).

- The Medicare Part B deductible and the coinsurance or copayment do **not** apply for screening Pap test services paid under the Clinical Laboratory Fee Schedule (Table 1) when billed to the carrier/AB MAC.
- The Part B deductible is also waived for screening Pap test services paid under the MPFS (Table 2 and Table 3); however, the coinsurance or copayment **does** apply when billed to the carrier/AB MAC.

Additional information about the MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Additional information about the Clinical Laboratory Fee Schedule can be found at http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Additional information about OPPS can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS on the CMS website.

NOTE: The same physician may report a covered Evaluation and Management (E/M) visit and code Q0091 for the same date of service if the E/M visit is for a separately identifiable service. In this case, modifier -25 must be reported with the E/M service and the medical records must clearly document the E/M service reported. Both procedure codes are to be shown as separate line items on the claim. These services can also be performed separately during separate office visits.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Medicare bases reimbursement for most screening Pap test services on the Clinical Laboratory Fee Schedule or the MPFS.

The Medicare Part B deductible and the coinsurance or copayment do **not** apply for screening Pap test services paid under the Clinical Laboratory Fee Schedule (Table 1) when billed to the FI/AB MAC [with the exception of HCPCS code Q0091 (Table 3)].

The Medicare Part B deductible is also waived for screening Pap test services paid under the MPFS (Table 2); however, the coinsurance or copayment **does** apply when billed to the FI/AB MAC.

For HCPCS code Q0091, the Medicare Part B deductible is waived; however, coinsurance or copayment does apply when billed to the FI/AB MAC. Payment for HCPCS code Q0091 in a hospital outpatient department is based on the Outpatient Prospective Payment System (OPPS). A SNF is paid based on the MPFS. A CAH is paid on a reasonable cost basis. RHC/FQHC payment for this code is based on the all-inclusive rate for the professional component.

Reasons for Claim Denial

Following are examples of situations when Medicare may deny coverage of screening Pap tests:

- The beneficiary who is not at high risk has received a covered screening Pap test within the past two years.
- The beneficiary who is at high risk has received a covered screening Pap test during the past year.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Medicare providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Screening Pap Tests

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Centers for Disease Control and Prevention
Information on cervical cancer is available in both English and Spanish.
http://www.cdc.gov/cancer/cervical/basic_info/screening

Clinical Laboratory Fee Schedule Information
http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

How Many Women Get Cancer of the Cervix?
A cervical cancer fact sheet produced by the American Cancer Society
http://www.cancer.org/docroot/CRI/content/CRI_2_2_1X_How_many_women_get_cancer_of_the_cervix_8.asp?sitearea=

Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 280.4
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 30
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

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The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

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Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Preventive Services Educational Resource Website
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National Cancer Institute
http://www.cancer.gov

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

National Provider Identifier Information
http://www.cms.hhs.gov/NationalProvIdentStand

Outpatient Prospective Payment System Information
http://www.cms.hhs.gov/HospitalOutpatientPPS

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Notes

Screening Pelvic Examination

Overview

A screening pelvic examination is an important part of preventive health care for all adult women. A pelvic examination is performed to help detect pre-cancers, genital cancers, infections, sexually transmitted diseases (STDs), other reproductive system abnormalities, and genital and vaginal problems. STDs in women may be associated with cervical cancer. In particular, one STD, human papillomavirus (HPV), causes genital warts, and cervical and other genital cancers. The pelvic examination is also used to help find fibroids or ovarian cancers, as well as to evaluate the size and position of a woman's pelvic organs. In addition, a Medicare screening pelvic examination includes a breast examination, which can be used as a tool for detecting, preventing, and treating breast masses, lumps, and breast cancer. The screening pelvic examination benefit covered by Medicare can help beneficiaries maintain the general overall health of their lower genitourinary tract.

Medicare's coverage of the screening pelvic examination was created as a result of the implementation of the Balanced Budget Act of 1997 (BBA). The BBA includes coverage of a screening pelvic examination for all female beneficiaries, effective January 1, 1998.

Risk Factors

High risk factors for cervical and vaginal cancer include the following:

- Early onset of sexual activity (under 16 years of age),
- Multiple sexual partners (5 or more in a lifetime),
- History of a sexually transmitted disease [including human papillomavirus (HPV) and/or Human Immunodeficiency Virus (HIV) infection],
- Fewer than 3 negative Pap tests or no Pap test within the previous 7 years, and
- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

Coverage Information

Medicare provides coverage of a screening pelvic examination for all female beneficiaries when performed by a doctor of medicine or osteopathy, or by a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist who is authorized under State law to perform the examination (this examination does not have to be ordered by a physician or other authorized practitioner). Frequency of coverage is provided as follows:

Covered once every 12 months:

Medicare provides coverage of a screening pelvic examination annually (i.e., at least 11 months have passed following the month in which the last Medicare-covered pelvic examination was performed) for beneficiaries that meet one (or both) of the following criteria:

- There is evidence that the woman is in one of the high risk categories (previously identified) for developing cervical or vaginal cancer, has other specified personal history presenting hazards to health, **and** at least 11 months have passed following the month that the last covered screening pelvic examination was performed.
- A woman of childbearing age had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during the preceding 3 years.

Covered once every 24 months:

Medicare provides coverage of a screening pelvic examination for all asymptomatic female beneficiaries every 2 years (i.e., at least 23 months have passed following the month in which the last Medicare-covered pelvic examination was performed).

Medicare's covered pelvic examination includes a complete physical examination of a woman's external and internal reproductive organs by a physician or qualified non-physician practitioner. In addition, the pelvic examination includes a clinical breast examination, which aids in helping to detect and find breast cancer or other abnormalities.

Who Are Qualified Physicians and Non-Physician Practitioners?

A screening pelvic examination is covered when performed by a doctor of medicine or osteopathy, or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist), who is authorized under State law to perform the examination. This examination does not have to be ordered by a physician or other authorized practitioner.

NOTE: The term "woman of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings.

A screening pelvic examination, with or without specimen collection for smears and cultures, should include **at least seven** of the following elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;
- External genitalia (for example, general appearance, hair distribution, or lesions);
- Urethral meatus (for example, size, location, lesions, or prolapse);
- Urethra (for example, masses, tenderness, or scarring);
- Bladder (for example, fullness, masses, or tenderness);
- Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
- Cervix (for example, general appearance, lesions or discharge);
- Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
- Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); or
- Anus and perineum.

Medicare provides coverage for the screening pelvic examination as a Medicare Part B benefit. The coinsurance or copayment applies for the pelvic and breast examinations. There is no Medicare Part B deductible.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) code listed in Table 1 to report Medicare-covered screening pelvic examination services:

Table 1 – HCPCS Code for the Screening Pelvic Examination Services

HCPCS Code	Code Descriptor
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination

Diagnosis Requirements

When a Medicare provider files a claim for a screening pelvic examination and/or a screening Pap test, one of the screening ("V") diagnosis codes listed in Tables 2 and 3 must be used. Code selection depends on whether the beneficiary is classified as low risk or high risk. This diagnosis code, along with other applicable diagnosis codes, must also be reported. Failure to report the V72.31, V76.2, V76.47, V76.49, or V15.89 diagnosis code will result in denial of the claim.

Table 2 – Diagnosis Codes for Low Risk Screening Pelvic Examination Services

Low-Risk ICD-9-CM Diagnosis Code	Code Descriptor
V72.31	Routine Gynecological Examination **NOTE:** This diagnosis should only be used when the provider performs a full gynecological examination.
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasms, vagina
V76.49	Special screening for malignant neoplasms, other sites **NOTE:** Providers use this diagnosis for women without a cervix.

Table 3 – Diagnosis Code for High Risk Screening Pelvic Examination Services

High-Risk ICD-9-CM Diagnosis Code	Code Descriptor
V15.89	Other

Coding Tips

A screening pelvic examination and a screening Pap test can be performed during the same encounter. When this happens, both procedure codes should be shown as separate line items on the claim.

The same physician may report a covered Evaluation and Management (E/M) visit and code Q0091 for the same date of service if the E/M visit is for a separately identifiable service. In this case, modifier -25 must be reported with the E/M service and the medical records must clearly document the E/M service reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately during separate office visits.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report HCPCS code G0101 and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit those claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

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Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

The screening pelvic examination service may be billed to an FI/AB MAC by the technical component category, which is defined as services rendered outside the scope of the physician's interpretation of the results of an examination, or the professional component category, which is defined as a physician's interpretation of the results of an examination. When submitting claims to FIs/AB MACs, Medicare providers must report HCPCS code G0101, the appropriate revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for pelvic screening services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 4:

Table 4 – Facility Types, Types of Bills, and Revenue Codes for Screening Pelvic Examination Services

Facility Type	Type of Bill	Revenue Codes
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X	0770
Hospital Outpatient	13X	0770
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0770
SNF Outpatient	23X	0770
CAH*	85X	0770
Rural Health Clinic (RHC)	71X	052X
Federally Qualified Health Center (FQHC)	73X	052X

***NOTE:** Method I – All technical components are paid using standard institutional billing practices.

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X. (This pertains to physicians/practitioners who have reassigned their billing rights to the Method II CAH.)

Additional Billing Instructions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

RHCs and FQHCs should follow these additional billing instructions to ensure that proper payment is made for services and to allow the Common Working File (CWF) to perform age and frequency editing.

There are specific billing and coding requirements for the technical component when a screening pelvic examination is furnished in an RHC or a FQHC. The technical component is defined as services rendered outside the scope of the physician's interpretation of the results of an examination.

Technical Component for Provider-Based RHCs and FQHCs:

For a screening pelvic examination, the base provider must bill the FI/AB MAC under bill type 13X, 22X, 23X, or 85X as appropriate using the base provider's ID number following the billing instructions applicable to the base provider. Do not use the RHC/FQHC provider ID number since these services are not covered as RHC/FQHC services.

Technical Component for Independent RHCs and FQHCs:

For a screening pelvic examination, the provider of the service must bill the carrier/AB MAC under their practitioner number following the instructions for billing the carrier/AB MAC. Do not use the RHC/FQHC provider ID number since these services are not covered as RHC/FQHC services.

Professional Component for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:

When a screening pelvic examination is furnished within an RHC/FQHC by a physician or qualified non-physician, the screening pelvic examination is considered an RHC/FQHC service. RHCs/FQHCs will use revenue code 052X to report the related visit. The provider (RHC/FQHC) of a screening pelvic examination must bill the FI/AB MAC under bill type 71X or 73X respectively.

NOTE: Independent RHCs and Freestanding FQHCs are freestanding practices that are not part of a hospital, Skilled Nursing Facility (SNF), or Home Health Agency (HHA). Provider-based RHCs and FQHCs are integral and subordinate parts of hospitals, SNFs, or HHAs, and under common licensure, governance, and professional supervision.

Reimbursement Information

General Information

Medicare provides coverage for the screening pelvic examination as a Medicare Part B benefit. The coinsurance or copayment applies for the pelvic and breast examinations. The Medicare Part B deductible does not apply.

See the National Correct Coding Initiative Edits web page for currently applicable bundled carrier processed procedures at http://www.cms.hhs.gov/NationalCorrectCodInitEd on the CMS website.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare bases reimbursement for the screening pelvic examination service on the Medicare Physician Fee Schedule (MPFS).

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for the screening pelvic examination service depends on the type of facility providing the service. Table 5 lists the type of payment that facilities receive for screening pelvic examination services:

Table 5 – Facility Payment Methodology for Screening Pelvic Examination Services

If the Facility Is a…	Then Payment Is Based On…
Hospital	Outpatient Prospective Payment System (OPPS)
Skilled Nursing Facility (SNF)	Medicare Physician Fee Schedule (MPFS)
Critical Access Hospital (CAH)	Reasonable Cost Basis
RHC	All-inclusive rate for the **professional component**
FQHC	Provider's payment method for the **technical component**

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of screening pelvic examination services:

- A beneficiary who is not at high risk has received a covered screening pelvic examination service within the past two years.
- A beneficiary who is at high risk has received a covered screening pelvic examination service during the past year.

Medicare providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Screening Pelvic Examination

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Centers for Disease Control and Prevention
Information on cervical cancer and reducing the risk is available in both English and Spanish.
http://www.cdc.gov/cancer/cervical/basic_info/screening

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 40
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule and OPPS.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Cancer Institute
http://www.cancer.gov

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

National Provider Identifier Information
http://www.cms.hhs.gov/NationalProvIdentStand

Beneficiary-related resources can be found in Reference F of this Guide.

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Colorectal Cancer Screening

Overview

Primarily affecting men and women ages 50 and older, colorectal cancer is the third leading cause of cancer deaths in the United States. The risk of developing the disease increases with age.[1] Patients with colorectal cancer rarely display any symptoms, and the cancer can progress unnoticed and untreated until it becomes fatal. The most common symptom of colorectal cancer is bleeding from the rectum. Other common symptoms include cramps, abdominal pain, intestinal obstruction, or a change in bowel habits.

Colorectal cancer is largely preventable through screening, which can find pre-cancerous polyps (growths in the colon) that can be removed before they develop into cancer. Screening can also detect cancer early when it is easier to treat and cure. Screenings are performed to diagnose or determine a beneficiary's risk for developing colorectal cancer. Colorectal cancer screening may consist of several different screening services to test for polyps or colorectal cancer. Each colorectal cancer screening can be used alone or in combination with each other.

Medicare's colorectal cancer screening benefit was created as a result of the implementation of the Balanced Budget Act of 1997 (BBA). Medicare began coverage of colorectal cancer screening services on January 1, 1998 for the early detection of colorectal cancer. The BBA provided coverage for various colorectal cancer screening examinations subject to certain coverage, frequency, and payment limitations. Subsequent legislation expanded the colorectal screening benefit to include colonoscopies for Medicare beneficiaries not at high risk for developing colorectal cancer and amended the conditions for payment for a screening sigmoidoscopy.

Medicare provides coverage of the following colorectal cancer screening services for the early detection of colorectal cancer:

- Fecal Occult Blood Test (FOBT),
- Flexible Sigmoidoscopy,
- Colonoscopy, and
- Barium Enema (as an alternative to a covered screening flexible sigmoidoscopy or a screening colonoscopy).

NOTE: At this time, Medicare does not cover screening Deoxyribonucleic Acid (DNA) stool tests as part of the colorectal cancer screening benefit.

The **Fecal Occult Blood Test** checks for occult or hidden blood in the stool. A Medicare provider gives a FOBT card to the beneficiary, and the beneficiary can perform the test at home. The beneficiary takes stool samples and places them on the test cards and then returns them to the doctor or a laboratory. The FOBT consists of either one of two types of tests:

1. Fecal Occult Blood Test, 1-3 Simultaneous Determinations -- A guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools.

1 The American Cancer Society, Inc. 2008. What Are the Key Statistics for Colorectal Cancer? [online]. Atlanta, GA: The American Cancer Society, Inc., 18 March 2009 [cited 22 June 2009]. Available from the World Wide Web: (http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_colon_and_rectum_cancer.asp?sitearea=).

OR

2. Immunoassay, Fecal Occult Blood Test, 1-3 Simultaneous Determinations -- An immunoassay (or immunochemical) test for antibody activity in which the beneficiary completes the test by taking the appropriate number of samples according to the specific manufacturer's instructions.

The **Flexible Sigmoidoscopy** is a procedure used to check for polyps and cancer. It is administered using a thin, flexible, lighted tube called a sigmoidoscope that provides direct visualization of the rectum and lower third of the colon. The procedure allows for biopsies of polyps and cancers to be taken as well as polyp removal.

The **Colonoscopy** is a procedure similar to the flexible sigmoidoscopy, except a longer, thin, flexible, lighted tube called a colonoscope is used to provide direct visualization of the rectum and the entire colon. This procedure is used to check for polyps and cancer in the rectum and the entire colon. Most polyps and some cancers can be found and removed during the procedure.

The **Barium Enema** is a procedure in which the beneficiary is given an enema with barium. The X-ray images are taken of the rectum and entire colon that allows the physician to see the outline of the beneficiary's colon to check for polyps or other abnormalities.

Risk Factors

Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp,
- A family history of familial adenomatous polyposis,
- A family history of hereditary nonpolyposis colorectal cancer,
- A personal history of adenomatous polyps,
- A personal history of colorectal cancer, or
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

Coverage Information

Medicare provides coverage of colorectal cancer screening for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema rendered as an alternative to a screening colonoscopy.

Medicare provides coverage for colorectal cancer screening as a Medicare Part B benefit. The beneficiary will pay nothing for the FOBT (there is no deductible and no coinsurance or copayment for this benefit). For all other procedures, the coinsurance or copayment applies; however, there is no deductible.

NOTE: Medicare does not waive the deductible if the colorectal cancer screening test becomes a diagnostic colorectal test; that is, the service actually results in a biopsy or removal of a lesion or growth.

If the flexible sigmoidoscopy or colonoscopy procedure is performed in a hospital outpatient department or in an ambulatory surgical center, the beneficiary will pay 25 percent of the Medicare-approved amount.

The following are the coverage criteria for each colorectal cancer screening test/procedure.

Screening Fecal Occult Blood Test (HCPCS G0328 and CPT 82270)

Medicare provides coverage of a screening FOBT annually (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed) for beneficiaries age 50 and older. This screening requires a written order from the beneficiary's attending physician.

NOTE: Payment may be made for an immunoassay-based FOBT [Healthcare Common Procedure Coding System (HCPCS) code (G0328)] as an alternative to the guaiac-based FOBT [Common Procedural Terminology (CPT) code (82270)]. However, Medicare will only provide coverage for one FOBT per year, either CPT code 82270 or HCPCS code G0328, but not both.

Who Can Order the Screening Fecal Occult Blood Test?

The screening FOBT requires a written order from the beneficiary's attending physician. Attending physician means a doctor of medicine or osteopathy who is fully knowledgeable about the beneficiary's medical condition and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

Screening Flexible Sigmoidoscopy (HCPCS G0104)

Medicare provides coverage of a screening flexible sigmoidoscopy for beneficiaries age 50 or older, without regard to risk.

Who Can Perform a Screening Flexible Sigmoidoscopy?

Screening flexible sigmoidoscopies must be performed by a doctor of medicine or osteopathy, or by a physician assistant, nurse practitioner, or clinical nurse specialist.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening flexible sigmoidoscopy once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for beneficiaries at high risk for colorectal cancer.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening flexible sigmoidoscopy once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for beneficiaries age 50 and older **unless** the beneficiary does not meet the high risk criteria for developing colorectal cancer **and** the beneficiary has had a screening colonoscopy (HCPCS code G0121) within the preceding 10 years. If the beneficiary has had a screening colonoscopy within the preceding 10 years, then the next screening flexible sigmoidoscopy will be covered only after at least 119 months have passed following the month in which the last covered screening colonoscopy (HCPCS code G0121) was performed.

NOTE: If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed rather than code HCPCS code G0104.

Screening Colonoscopy (HCPCS codes G0105 and G0121)

Medicare provides for coverage of a screening colonoscopy for all beneficiaries without regard to age. A doctor of medicine or osteopathy must perform this screening.

Who Can Perform a Screening Colonoscopy?

Screening colonoscopies must be performed by a doctor of medicine or osteopathy.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening colonoscopy (HCPCS code G0105) once every 2 years for beneficiaries at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered HCPCS code G0105 screening colonoscopy was performed).

NOTE: If during the course of the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed rather than code HCPCS code G0105.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening colonoscopy (HCPCS code G0121) for beneficiaries who do not meet the criteria for being at high risk for developing colorectal cancer, under the following conditions:

- At a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered HCPCS code G0121 screening colonoscopy was performed).
- If the beneficiary otherwise qualifies to have a covered screening colonoscopy (HCPCS code G0121) based on the above **but** has had a covered screening flexible sigmoidoscopy (HCPCS code G0104), then Medicare may cover a screening colonoscopy (HCPCS code G0121) only after at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy (HCPCS code G0104) was performed.

NOTE: If during the course of the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed rather than code HCPCS code G0121.

Screening Barium Enema (HCPCS codes G0106 and G0120)

Medicare provides coverage of a screening barium enema examination as an alternative to either a high risk screening colonoscopy (HCPCS code G0105) or a screening flexible sigmoidoscopy (HCPCS code G0104).

Who Can Order a Screening Barium Enema?

The screening barium enema must be ordered by a doctor of medicine or osteopathy.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening barium enema (HCPCS code G0120), as an alternative to a screening colonoscopy (HCPCS code G0105), every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening barium enema or the last screening colonoscopy was performed) for beneficiaries at high risk for colorectal cancer, without regard to age. The same frequency parameters for screening colonoscopies apply.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening barium enema (HCPCS code G0106), as an alternative to a screening flexible sigmoidoscopy (HCPCS code G0104), once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening barium enema or screening flexible sigmoidoscopy was performed) for beneficiaries not at high risk for colorectal cancer, but who are age 50 or older. The same frequency parameters for screening sigmoidoscopies apply.

The screening barium enema (preferably a double contrast barium enema) must be ordered in writing after a determination that the procedure is appropriate. If the individual cannot withstand a double contrast barium enema, the attending physician may order a single contrast barium enema. The attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the estimated screening potential for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, for the same individual. The screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described previously for the screening double contrast barium enema examination.

Documentation

Documentation in the beneficiary's medical record must identify any risk factors for tests/procedures performed.

When a covered procedure is attempted and unable to be completed, Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event the Medicare Contractor needs the information to document the incomplete procedure.

If a screening barium enema is provided, the documentation should reflect that the procedure was performed:

- As an alternative to either a screening flexible sigmoidoscopy or a high risk screening colonoscopy, and
- Because it is determined that the screening potential for the barium enema is equal to or greater than the estimated screening potential for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, for the same individual.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS)/Common Procedural Terminology (CPT) codes listed in Table 1 to report colorectal cancer screening services:

Table 1 – HCPCS/CPT Codes for Colorectal Screening Services

HCPCS/CPT Code	Code Descriptor
G0104	Colorectal cancer screening; flexible sigmoidoscopy
G0105	Colorectal cancer screening; colonoscopy on individual at high risk

HCPCS/CPT Code	Code Descriptor
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
G0107*	Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0122	Colorectal cancer screening; barium enema
G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous

***NOTE:** For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report G0107.

Non-Covered Colorectal Cancer Screening Services

Medicare covers colorectal barium enemas only in lieu of covered screening flexible sigmoidoscopies (HCPCS code G0104) or covered screening colonoscopies (HCPCS code G0105). However, there may be instances when the beneficiary has elected to receive the barium enema for colorectal screening other than specifically for these purposes. In such situations, the beneficiary may require a formal denial of the service from Medicare in order to bill a supplemental insurer who may cover the service. These non-covered barium enemas are to be identified by HCPCS code G0122 (colorectal cancer screening; barium enema). Medicare providers should not use HCPCS code G0122 for covered barium enema services, that is, those rendered in place of the covered screening colonoscopy or covered flexible sigmoidoscopy. The beneficiary is liable for payment of the non-covered barium enema.

Diagnosis Requirements

For the screening colonoscopy, the beneficiary is not required to have any present signs/symptoms. However, when Medicare providers bill for the "high risk" beneficiary, the screening diagnosis code on the claim must reflect at least one of the high risk conditions described previously.

Listed in Table 2, Table 3, and Table 4 are examples of diagnoses that meet high risk criteria for colorectal cancer. **This is not an all-inclusive list.** There may be more instances of conditions that could be coded and would be applicable.

Table 2 – Personal History ICD-9-CM Codes

ICD-9-CM Code	Code Descriptor
V10.05	Personal history of malignant neoplasm of large intestine
V10.06	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

Table 3 – Chronic Digestive Disease Condition ICD-9-CM Codes

ICD-9-CM Code	Code Descriptor
555.0	Regional enteritis of small intestine
555.1	Regional enteritis of large intestine
555.2	Regional enteritis of small intestine with large intestine
555.9	Regional enteritis of unspecified site
556.0	Ulcerative (chronic) enterocolitis
556.1	Ulcerative (chronic) ileocolitis
556.2	Ulcerative (chronic) proctitis
556.3	Ulcerative (chronic) proctosigmoiditis
556.8	Other ulcerative colitis
556.9	Ulcerative colitis, unspecified

Table 4 – Inflammatory Bowel ICD-9-CM Codes

ICD-9-CM Code	Code Descriptor
558.2	Toxic gastroenteritis and colitis
558.9	Other and unspecified noninfectious gastroenteritis and colitis

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT codes and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit those claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT codes, the appropriate revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit those claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for colorectal cancer screening when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 5:

Table 5 – Facility Types, Types of Bills, and Revenue Codes for Colorectal Cancer Screening Services

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	See Table 6
Hospital Non-patient Laboratory Specimens	14X**	030X (HCPCS/CPT 82270 and G0328 only)

Facility Type	Type of Bill	Revenue Code
Skilled Nursing Facility (SNF) Inpatient Part B	22X	See Table 7
SNF Outpatient	23X	See Table 7
Ambulatory Surgical Center (ASC)	83X	030X for HCPCS/CPT 82270, G0328 The appropriate revenue code when reporting any other surgical procedure for HCPCS G0104, G0105, G0121
Critical Access Hospital (CAH)*	85X	See Table 6

***NOTE:** Method I – All technical components are paid using standard institutional billing practices.

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X. For the technical or facility component, use revenue code 075X or another appropriate revenue code.

****NOTE:** All hospitals submitting claims containing CPT code 82270 and HCPCS code G0328 for non-patient laboratory specimens should use TOB 14X.

Table 6 – Procedure, Revenue Code, and Associated HCPCS/CPT Codes for Facilities Using Types of Bills 13X, 83X, and 85X

Screening Test/Procedure	Revenue Code	HCPCS/CPT Code
Fecal Occult Blood Test	030X	82270, G0107*, G0328
Barium Enema	032X	G0106, G0120 (G0122 non-covered)
Flexible Sigmoidoscopy	The appropriate revenue code when reporting any other surgical procedure for bill types 13X, 83X, or 85X	G0104
Colonoscopy-High Risk	The appropriate revenue code when reporting any other surgical procedure for bill types 13X, 83X, or 85X	G0105, G0121

***NOTE:** For claims with dates of service **prior** to January 1, 2007, physicians, suppliers, and providers report G0107.

NOTE: Hospital and Critical Access Hospital (CAH) providers should submit TOBs 13X or 85X. Outpatient surgery performed by a hospital not bound by the Outpatient Prospective Payment System (OPPS) requirements should submit TOB 83X.

Special Billing Instructions for Hospital Inpatients

When these tests/procedures are provided to inpatients of a hospital, the inpatients are covered under this benefit. However, the Medicare provider should bill on TOB 13X using the discharge date of the hospital stay to avoid editing.

See the National Correct Coding Initiative Edits web page for currently applicable bundled carrier processed procedures at http://www.cms.hhs.gov/NationalCorrectCodInitEd on the CMS website.

Special Billing Instructions for Skilled Nursing Facilities (SNFs)

When colorectal cancer screening tests are provided to inpatients of a SNF, the Medicare provider should bill the test on TOB 22X using the actual date of service.

Table 7 – Procedure, Revenue Code, and Associated HCPCS/CPT Codes for SNFs

Screening Test/Procedure	Revenue Code	HCPCS/CPT Code
Fecal Occult Blood Test	030X	82270, G0107*
Fecal Occult Blood Test, Immunoassay	030X	G0328
Barium Enema	032X	G0106, G0120 (G0122 non-covered)
Flexible Sigmoidoscopy	The appropriate revenue code when reporting any other surgical procedure	G0104, G0105, G0121

***NOTE:** For claims with dates of service **prior** to January 1, 2007, physicians, suppliers, and providers report G0107.

Reimbursement Information

General Information

There is no Medicare Part B deductible or coinsurance/copayment for the FOBT. For all other colorectal screening tests, there is no deductible. Coinsurance or copayments apply.

Payment of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare makes payment to physicians for colorectal screening procedures under the Medicare Physician Fee Schedule (MPFS) when billed to the carrier/AB MAC. Medicare makes payment to ambulatory surgical centers (ASCs) for facility services furnished in connection with colorectal screening procedures (included on the ASC list of covered surgical procedures) under the ASC fee schedule when billed to the carrier/AB MAC. Coinsurance or copayment applies. (The beneficiary coinsurance for the ASC facility fee is 25 percent of the ASC fee schedule payment amount.) Beginning January 1, 2007, there is no deductible for colorectal cancer screening tests.

Additional information about the MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Additional information about the Clinical Laboratory Fee Schedule can be found at http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Additional information about OPPS can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS on the CMS website.

NOTE: Medicare does not waive the deductible if the colorectal cancer screening test becomes a diagnostic colorectal test; that is, the service results in a biopsy or removal of a lesion or growth.

Reimbursement for FOBTs is paid under the Clinical Laboratory Fee Schedule, with the exception of CAHs, which are paid on a reasonable cost basis. Deductible and coinsurance do not apply for this type of screening.

Payment by Carriers/AB MACs of Interrupted and Completed Colonoscopies

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay the physician for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy, as long as coverage conditions are met for the incomplete procedure. When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with modifier -53 to indicate that the procedure was interrupted.

When a covered colonoscopy is attempted in an ASC and is discontinued due to extenuating circumstances that threaten the well-being of the patient prior to the administration of anesthesia, but after the beneficiary has been taken to the procedure room, the ASC is to suffix the colonoscopy code with modifier -73 and payment will be reduced by 50 percent. If the colonoscopy is begun (e.g., anesthesia administered, scope inserted, incision made) but is discontinued due to extenuating circumstances that threaten the well-being of the patient, the ASC is to suffix the colonoscopy code with modifier -74 and the procedure will be paid at the full amount.

Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event that the Medicare Contractor needs it to document the incomplete procedure.

When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met. This policy is applied to both screening and diagnostic colonoscopies.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for colorectal cancer screening procedures is dependent upon the type of facility providing the service. Table 8 lists the type of payment that facilities receive for colorectal screening services:

Table 8 – Types of Payments Received by Facilities for Colorectal Cancer Screening Services

Type of Colorectal Screening	Facility	Type of Payment	Deductible/Coinsurance
Fecal Occult Blood Tests (82270, G0328, and G0107*)	CAH	Reasonable Cost Basis	Deductible and coinsurance do not apply for this type of screening.
Fecal Occult Blood Tests (82270, G0328, and G0107*)	All other types of facilities	Clinical Laboratory Fee Schedule (Medicare pays 100% of the Clinical Laboratory Fee Schedule amount or the provider's actual charge, whichever is lower.)	Deductible and coinsurance do not apply for this type of screening.
Flexible Sigmoidoscopy (G0104)	CAH	Reasonable Cost Basis	Deductible does not apply. Coinsurance applies for this type of screening, with one exception: For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount.
Flexible Sigmoidoscopy (G0104)	Hospital Outpatient Departments	Outpatient Prospective Payment System (OPPS)	Deductible does not apply. Coinsurance applies for this type of screening, with one exception: For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount.
Flexible Sigmoidoscopy (G0104)	SNF Inpatient (for Medicare Part B Services)	Medicare Physician Fee Schedule (MPFS)	Deductible does not apply. Coinsurance applies for this type of screening, with one exception: For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount.

Type of Colorectal Screening	Facility	Type of Payment	Deductible/Coinsurance
Colonoscopy (G0105 and G0121)	CAH	Reasonable Cost Basis	Deductible does not apply. Coinsurance apply for this type of screening, with the exception of the following: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure. For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount.
Colonoscopy (G0105 and G0121)	Hospital Outpatient Departments	OPPS	Deductible does not apply. Coinsurance apply for this type of screening, with the exception of the following: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure. For screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount.
Barium Enemas (G0106 and G0120)	CAH	Reasonable Cost Basis	Deductible does not apply. Coinsurance apply for this type of screening, with one exception: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure.
Barium Enemas (G0106 and G0120)	Hospital Outpatient Departments	OPPS	Deductible does not apply. Coinsurance apply for this type of screening, with one exception: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure.

Type of Colorectal Screening	Facility	Type of Payment	Deductible/Coinsurance
Barium Enemas (G0106 and G0120)	SNF	MPFS	Deductible does not apply. Coinsurance apply for this type of screening, with one exception: For screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure.

In addition, the colorectal cancer screening codes must be paid at rates consistent with the colorectal diagnostic codes.

***NOTE:** For claims with dates of service **prior** to January 1, 2007, physicians, suppliers, and providers report G0107.

NOTE: Beginning January 1, 2008, colorectal cancer screening sigmoidoscopies (G0104) are payable in ASCs. The deductible does not apply for the screening and the beneficiary pays 25 percent of the Medicare-approved amount.

Payment by FIs/AB MACs of Interrupted and Completed Colonoscopies

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy as long as the coverage conditions are met for the incomplete procedure. The Common Working File (CWF) will not apply the frequency standards associated with screening colonoscopies. When submitting a facility claim for the interrupted colonoscopy, providers are to suffix the colonoscopy HCPCS codes with modifier -73 or -74, as appropriate, to indicate that the procedure was interrupted. Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event that the Medicare Contractor needs it to document the incomplete procedure.

When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure, as long as coverage conditions are met. The frequency standards will be applied by the CWF. This policy is applied to both screening and diagnostic colonoscopies.

Critical Access Hospital (CAH) Payment by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs) of Interrupted and Completed Colonoscopies

In situations where a CAH has elected payment Method II for CAH beneficiaries, payment should be consistent with payment methodologies currently in place. As such, CAHs that elect Method II should use payment modifier -53 to identify an incomplete screening colonoscopy [physician professional service(s) billed with revenue code 096X, 097X, and/or 098X]. Such CAHs will also bill the technical or facility component of the interrupted colonoscopy in revenue code 075X (or other appropriate revenue code) using modifier -73 or -74, as appropriate.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of colorectal cancer screening:

- The beneficiary is under age 50.
- The beneficiary does not meet the criteria of being at high risk of developing colorectal cancer.
- The beneficiary has exceeded Medicare's frequency parameters for coverage of colorectal cancer screening services.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Colorectal Cancer Screening

Resource Materials

The American Cancer Society
Website offers free materials to help clinicians encourage colorectal cancer screening among patients 50 and older. Includes a toolbox, "How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide," for primary care clinicians that outlines an efficient way to get every patient in for the colorectal cancer screening tests he or she needs.
http://www.cancer.org/docroot/PRO/PRO_4_ColonMD.asp

The American Cancer Society's ACS Cancer Facts & Figures 2008
http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Clinical Laboratory Fee Schedule Information
http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Medicare Benefit Policy Manual – Pub.100-02, Chapter 15, Section 280.2
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 60
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule and OPPS.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Beneficiary-related resources can be found in Reference F of this Guide.

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Matters Articles
http://www.cms.hhs.gov/MLNMattersArticles

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

The National Cancer Institute's Colorectal Cancer Prevention
http://www.nci.nih.gov/cancertopics/pdq/prevention/colorectal/Patient/page2

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

Outpatient Prospective Payment System Information
http://www.cms.hhs.gov/HospitalOutpatientPPS

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

What Are the Key Statistics for Colorectal Cancer?
A colorectal cancer fact sheet produced by the American Cancer Society.
http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_colon_and_rectum_cancer.asp?sitearea=

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Prostate Cancer Screening

Overview

Prostate cancer is the second leading cause of cancer-related death in men and about 62 percent of all diagnosed prostate cancers are found in men age 65 or older.[1] Medicare provides coverage of prostate cancer screening tests/procedures for the early detection of prostate cancer. The two most common screenings used by physicians to detect prostate cancer are the screening Prostate Specific Antigen (PSA) blood test and the screening Digital Rectal Examination (DRE).

Section 4103 of the Balanced Budget Act of 1997 (BBA) provides for coverage of certain prostate cancer screening tests/procedures, subject to coverage, frequency, and payment limitations. Medicare began coverage of prostate cancer screening services January 1, 2000 for the early detection of prostate cancer.

The Prostate Specific Antigen (PSA) Blood Test

Prostate specific antigen is a protein the cells of the prostate gland produce and release into the blood. The screening PSA blood test measures the level of prostate specific antigen in an individual's blood. The Food and Drug Administration (FDA) approved the use of the PSA blood test along with a DRE to help detect prostate cancer in men age 50 and older. The FDA has also approved the PSA blood test to monitor patients with a history of prostate cancer to determine if the cancer recurs.[2]

PSA is a tumor marker for adenocarcinoma of the prostate that can help to predict residual tumors in the post-operative phase of prostate cancer. Three to six months following a radical prostatectomy, PSA is reported as providing a sensitive indicator of persistent disease. Six months following introduction of antiandrogen therapy, PSA is reported as capable of distinguishing patients with favorable response from those in whom limited response is anticipated.

Once a diagnosis has been established, PSA serves as a marker to follow the progress of most prostate tumors. The PSA test also aids in managing prostate cancer patients and in detecting metastatic or persistent disease in patients following treatment. The PSA test helps differentiate benign from malignant disease in men with lower urinary tract symptoms (e.g., hematuria, slow urine stream, hesitancy, urgency, frequency, nocturia, and incontinence). It is also of value for men with palpably abnormal prostate glands found during physical exam, and for men with other laboratory or imaging studies that suggest the possibility of a malignant prostate disorder. PSA testing may also be useful in the differential diagnosis of men presenting with, as yet, undiagnosed disseminated metastatic disease.

The screening PSA blood test is not perfect; however, it is the best blood test currently available for the early detection of prostate cancer. Since Medicare providers began using this test, the number of prostate cancers found at an early, curable stage has increased.

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1 The National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control. 2006. Prostate Cancer Screening: A Decision Guide [online]. Atlanta, GA: The National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control, The Centers for Disease Control and Prevention, The U.S. Department of Health and Human Services, 30 October 2007 [cited 21 November 2008]. Available from the World Wide Web: (http://www.cdc.gov/cancer/prostate/basic_info/).

2 The Cancer Information Service, a program of The National Cancer Institute. 2007. The Prostate-Specific Antigen (PSA) Test: Questions and Answers [online]. Bethesda, MD: The Cancer Information Service, a program of The National Cancer Institute, National Institutes of Health, The U.S. Department of Health and Human Services, 21 August 2007 [cited 21 November 2008]. Available from the World Wide Web: (http://www.cancer.gov/cancertopics/factsheet/Detection/PSA).

The Digital Rectal Examination (DRE)

The screening DRE is a clinical examination for checking the health of an individual's prostate gland. The prostate is checked for size and any irregularities or abnormalities of the prostate gland.

Risk Factors

All men are at risk for prostate cancer; however, a beneficiary is at high risk if:

- His father, brother, or son has a history of prostate cancer.

The following list gives the order of prostate cancer risk among ethnic groups from highest to lowest:

- African-Americans,
- Caucasians,
- Hispanics,
- Asians,
- Pacific Islanders, and
- Native Americans.

Coverage Information

Medicare provides coverage of an annual preventive prostate cancer screening PSA blood test and DRE once every 12 months for all male beneficiaries age 50 and older (coverage begins the day after the beneficiary's 50th birthday), if at least 11 months have passed following the month in which the last Medicare-covered screening PSA test or DRE was performed for the early detection of prostate cancer.

Calculating Frequency

When calculating frequency, to determine the 11-month period, the count starts beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received a screening PSA blood test in January 2009. The count starts beginning February 2009. The beneficiary is eligible to receive another screening PSA blood test in January 2010 (the month after 11 months have passed).

The Screening Prostate Specific Antigen (PSA) Blood Test

The screening PSA blood test must be ordered by the beneficiary's physician (doctor of medicine or osteopathy) or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is fully knowledgeable about the beneficiary's medical condition, and would be responsible for explaining the results of the test to the beneficiary.

Medicare provides coverage of the screening PSA blood test as a Medicare Part B benefit. The PSA blood test is a laboratory test for which neither the deductible nor coinsurance or copayment apply.

The Screening Digital Rectal Examination (DRE)

The screening DRE must be performed by a doctor of medicine or osteopathy, physician assistant, nurse practitioner, clinical nurse specialist, or by a certified nurse midwife who is authorized under State law to perform the examination, is fully knowledgeable about the beneficiary's medical condition, and is responsible for explaining the results of the examination to the beneficiary.

Medicare provides coverage of the screening DRE as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies for the DRE.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1 to report prostate cancer screening services:

Table 1 – HCPCS Codes for Prostate Cancer Screening Services

HCPCS Code	Code Descriptor
G0102	Prostate cancer screening; digital rectal examination
G0103	Prostate cancer screening; prostate specific antigen test (PSA)

IMPORTANT NOTE

When submitting claims for the annual preventive prostate cancer screening PSA blood test, it is important to bill for a screening test, which is covered once every 12 months, and not for a diagnostic test.

Diagnosis Requirements

Medicare providers must submit claims for prostate cancer screening DREs and screening PSA blood tests using screening ("V") code V76.44 (Special Screening for Malignant Neoplasms, Prostate). For further guidance, contact your Medicare Contractor.

Documentation

Documentation in the beneficiary's record must show the annual preventive screenings were ordered for the purpose of early detection of prostate cancer and that the beneficiary is age 50 or older.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS code G0102 or G0103, and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit those claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When Medicare providers are submitting claims to FIs/AB MACs, they must report the appropriate HCPCS codes G0102 or G0103, the appropriate revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format, except for RHCs and FQHCs, which bill only for the professional component.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

See the National Correct Coding Initiative Edits web page for currently applicable bundled carrier processed procedures at http://www.cms.hhs.gov/NationalCorrectCodInitEd on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for prostate cancer screening services when submitted with the following Types of Bills (TOBs) and associated revenue codes for prostate cancer services listed in Table 2:

Table 2 – Facility Types, Types of Bills, and Revenue Codes for Prostate Cancer Screening Services

Facility Type	Type of Bill	Revenue Codes
Hospital Inpatient Part B, including Critical Access Hospital (CAH)	12X	0770 – DRE 030X - PSA
Hospital Outpatient	13X	0770 – DRE 030X - PSA
Hospital Non-patient Laboratory Specimens, including CAH	14X	030X - PSA

Facility Type	Type of Bill	Revenue Codes
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0770 – DRE 030X - PSA
SNF Outpatient	23X	0770 – DRE 030X - PSA
Rural Health Clinic (RHC)	71X	052X - DRE only
Federally Qualified Health Center (FQHC)	73X	052X - DRE only
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0770 – DRE 030X - PSA
CAH*	85X	0770 – DRE 030X - PSA

***NOTE:** Method I – All technical components are paid using standard institutional billing practices.

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X.

Reimbursement Information

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for the screening DRE (HCPCS code G0102) is based on the Medicare Physician Fee Schedule (MPFS) and is bundled into payment for a covered Evaluation and Management (E/M) service [Current Procedural Terminology (CPT) codes 99201-99456 and 99499], when the two services are furnished to a beneficiary on the same day. If the DRE is the only service, or is provided as part of an otherwise non-covered service, HCPCS code G0102 would be payable separately if all other coverage requirements are met. The deductible and coinsurance or copayment apply when this service is provided.

Additional information about the MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Additional information about the Clinical Laboratory Fee Schedule can be found at http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Additional information about OPPS can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS on the CMS website.

Reimbursement for the screening PSA blood test (HCPCS code G0103) is based on the Clinical Laboratory Fee Schedule and is never bundled. The deductible and coinsurance or copayments do not apply to this service.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Medicare makes payment for screening PSA tests (G0103) under the Clinical Diagnostic Lab Fee Schedule for all type of bills (TOBs).

Medicare makes payment for screening DREs (G0102) under the payment methods listed in Table 3 for the following TOBs (These screening services are not bundled when billed to FIs/AB MACs):

Table 3 – Type of Bills and Payment Methods for Prostate Cancer Screening Services

If the Type of Bill Is…	Then Payment is Based On…
12X, 13X, 14X*	Outpatient Prospective Payment System (OPPS)
22X, 23X, 75X	Medicare Physician Fee Schedule (MPFS)
71X, 73X	Included in the All-Inclusive Rate
85X	Cost (Payment should be consistent with amounts paid for code 84153 or code 86316)

***NOTE:** Effective April 1, 2006, the type of bill 14X is for non-patient laboratory specimens only.

RHCs and FQHCs should include the charges on the claims for future inclusion in encounter rate calculations.

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of the annual preventive prostate cancer screening services:

- The beneficiary is not at least age 50 (coverage begins the day after the beneficiary's 50th birthday).
- The beneficiary has received a covered PSA/DRE during the past year.
- The beneficiary received a covered E/M service on the same day as the DRE from the physician (carrier/AB MAC only).

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Medicare providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Prostate Cancer Screening

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Clinical Laboratory Fee Schedule Information
http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 50
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

Outpatient Prospective Payment System Information
http://www.cms.hhs.gov/HospitalOutpatientPPS

Beneficiary-related resources can be found in Reference F of this Guide.

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Prostate Cancer Screening: A Decision Guide
An informational guide prepared by the Centers for Disease Control and Prevention.
http://www.cdc.gov/cancer/prostate/informed_decision_making.htm

The Prostate-Specific Antigen (PSA) Test: Questions and Answers
A Frequently Asked Questions document prepared by the Cancer Information Service, a program of the National Cancer Institute.
http://www.cancer.gov/cancertopics/factsheet/Detection/PSA

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Notes

Influenza, Pneumococcal, and Hepatitis B Vaccinations

Overview

Influenza, pneumococcal infections, and hepatitis B are vaccine-preventable diseases that cause substantial illness and premature death in the United States each year. During an average influenza season, nearly 5 to 20 percent of the population may contract the virus. About 41,000 Americans die each year from influenza and pneumonia, the 8th leading cause of death in the United States. The hepatitis B virus causes significant morbidity and mortality worldwide. According to the Centers for Disease Control and Prevention (CDC), an estimated 1.25 million Americans are chronically infected with hepatitis B. In the United States, chronic hepatitis B virus infection is responsible for about 5,000 annual deaths from cirrhosis of the liver and liver cancer. The Medicare Program provides coverage for the influenza, pneumococcal, and hepatitis B vaccinations and their administration. These vaccines are safe, effective, and can help reduce disease incident, morbidity, and mortality, and ultimately reduce health care costs.

Advisory Committee on Immunization Practices (ACIP)

The CDC Advisory Committee on Immunization Practices (ACIP) develops written recommendations for the routine administration of vaccines to the pediatric and adult populations, along with schedules regarding the appropriate periodicity, dosage, and contraindications applicable to the vaccines. ACIP is the only entity in the Federal government which makes such recommendations.

Clinicians should refer to published guidelines for current recommendations related to immunization. The latest ACIP recommendations regarding immunizations and vaccines can be found at http://www.cdc.gov/vaccines/recs/acip/default.htm on the Web.

Influenza (Flu) Virus Vaccine

Influenza, also known as the flu, is a contagious disease that is caused by influenza viruses and generally occurs during the winter months. It attacks the respiratory tract in humans (nose, throat, and lungs). Influenza is a serious illness that can lead to pneumonia. The risks for complications, hospitalizations, and deaths from influenza are higher among individuals aged 65 years and older, young children, and persons of any age with certain underlying health conditions than among healthy older children and younger adults. An annual influenza vaccination is still the best way to prevent influenza and its severe complications.

Risk Factors for Influenza

Medicare provides coverage of the influenza virus vaccine and its administration for all Medicare beneficiaries regardless of risk for the disease; however, some individuals are at greater risk for contracting influenza. Vaccination is recommended for individuals that fall within one or more high risk groups.

The ACIP identifies the following groups as being at high risk for serious complications from influenza:

- Individuals aged 50 or older;
- Children aged 6 months to 18 years;
- Pregnant women;
- Individuals of any age who have certain underlying health conditions, such as heart or lung disease, transplant recipients, or individuals with immunodeficiency [i.e., Acquired Immune Deficiency Syndrome (AIDS)]; and

- Individuals of any age who have certain underlying health conditions, such as spinal cord injuries, seizure disorders, or other neuromuscular disorders that can compromise respiratory functions.

The following individuals have been identified by ACIP as being at a greater risk than the general public for complications from influenza:

- Residents of nursing homes and long-term care facilities,
- Children aged 6 months - 18 years old on long-term aspirin therapy,
- Health care workers involved in direct patient care, and
- Out-of-home caregivers and household contacts of children less than 6 months of age or individuals in the high risk groups.

NOTE: All individuals 50 years of age and older should be encouraged to get the influenza vaccine, and individuals 65 years of age and older should be encouraged to get pneumococcal vaccinations. Medicare beneficiaries who are under these ages but have chronic conditions, such as heart disease, lung disease, diabetes, or end-stage renal disease (ESRD), should get both vaccinations.

NOTE: For general information about planning an influenza vaccination clinic, see Planning a Flu Vaccination Clinic at the end of this chapter.

Who Should Not Get the Influenza Virus Vaccine

Individuals in the following groups should not receive the influenza virus vaccine without the recommendation of their physician:

- Individuals with a severe allergy (i.e., anaphylactic allergic reaction) to hens' eggs or to components of the vaccine, or prior adverse reaction following influenza vaccination; and
- Individuals who previously had onset of Guillain-Barre´ syndrome during the six weeks after receiving the influenza virus vaccine.

Did You Know?

Unvaccinated health care professionals and their staff can spread the highly contagious influenza virus to their patients and are a key cause of influenza outbreaks among patients and long-term care residents.

Don't forget to immunize yourself and your staff.

Protect your patients. Protect your family. Protect yourself. Get your flu shot. Not the Flu.

For information on ACIP's immunization recommendations for health care professionals, see http://www.cdc.gov/vaccines/pubs/ACIP-list.htm on the Centers for Disease Control and Prevention (CDC) website.

Coverage Information

Coverage of the influenza virus vaccine and its administration was added to the Medicare Program on May 1, 1993. Medicare provides coverage for one influenza virus vaccine per flu season for all beneficiaries. This may mean that a beneficiary will receive more than one influenza vaccination in a 12-month period. Medicare may provide coverage for more than one influenza vaccination per flu season if it is reasonable and medically necessary.

Reminder

Influenza virus vaccine plus its administration are covered Part B benefits. Note that influenza virus vaccine is NOT a Part D covered drug.

Medicare does not require that the influenza virus vaccine be administered under a physician's order or supervision. Therefore, the beneficiary may receive the vaccine upon request without a physician's order. A physician is not required to be present during the vaccination for the beneficiary to receive coverage under Medicare; however, the law in individual States may require a physician's presence, a physician's order, or other physician involvement.

How Often will Medicare Pay for Influenza Vaccination?

Medicare will pay for the influenza virus vaccine once per flu season. In some cases this may mean twice in one year. For example, if a beneficiary received a vaccination in January 2009 for one flu season, the beneficiary could be inoculated again in October 2009 for another flu season.

Medicare provides coverage for the influenza virus vaccine and its administration as a Medicare Part B benefit. If the beneficiary receives the immunization from a Medicare-enrolled provider, the beneficiary will pay nothing (there is no deductible or copayment for this benefit).

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes listed in Table 1 to report influenza vaccination services.

Table 1 – HCPCS/CPT Codes for Influenza Virus Vaccine and Administration

HCPCS/CPT Code	Code Descriptor
90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use
G0008	Administration of influenza virus vaccine

Diagnosis Requirements

When a Medicare provider files a claim, they must report the appropriate diagnosis code. If the **sole** purpose for the visit was to receive the influenza virus vaccine or if the influenza virus vaccine is the only service billed on a claim, the provider must report diagnosis code V04.81.

However, if the purpose of the visit was to receive both the influenza virus vaccine **and** the pneumococcal vaccine, Medicare providers must report diagnosis code V06.6. The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes and descriptors are listed in Table 2:

Table 2 – Diagnosis Codes for Influenza

ICD-9-CM Diagnosis Code	Code Descriptor
V04.81	Need for prophylactic vaccination and inoculation against viral diseases; influenza
V06.6	Need for prophylactic vaccination and inoculation against combinations of diseases; Streptococcus pneumoniae (pneumococcus) and influenza

Billing Requirements

General Requirements

- All billers using the HIPAA 837 Institutional electronic claim format (or Form CMS-1450) and the HIPAA 837 Professional electronic claim format (or Form CMS-1500) should note that all data fields that are required for any institutional or professional claim are required for the vaccines and their administration. Physicians, qualified non-physician practitioners, and suppliers should bill in accordance with the instructions within provider manuals provided by the Medicare carrier/AB Medicare Administrative Contractor (MAC). Additionally, coding specific to these benefits is required.
- Medicare providers and suppliers are responsible for filling out required items on the claim forms with correct information obtained from the beneficiary. If roster billing for the influenza virus vaccine, the Medicare provider should ensure that key data elements such as "Date of Birth" provide sufficient beneficiary information for the contractor to resolve incorrect Health Insurance Claim Numbers (HICNs). However, if through other information on the claim or through beneficiary contact the contractor cannot resolve the problem, the claim will be rejected. For more information on roster billing, see the Mass Immunizers/Roster Billers section later in this chapter.
- If a physician provides other Medicare-covered services during the visit in which the immunization is given, the physician may code and bill those other medically necessary services, including Evaluation and Management (E/M) services. More information about Documentation Guidelines for Evaluation and Management Services is available at http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS website.

- Since the influenza vaccine benefit does not require any beneficiary coinsurance or deductible, a Medicare beneficiary has a right to receive this benefit without incurring any out-of-pocket expense.
- In addition, the entity that furnishes the influenza virus vaccine and the entity that administers the influenza virus vaccine are each required by law to submit a claim to Medicare on behalf of the beneficiary. The entity may bill Medicare for the amount not subsidized from its budget. For example, an entity that incurs a cost of $7.50 per influenza vaccination and pays $2.50 of the cost from its budget may bill the carrier/AB MAC the $5.00 cost that is not paid out of its budget.
- When an entity receives donated influenza virus vaccine or receives donated services for the administration of the influenza virus vaccine, the provider may bill Medicare for the portion of the vaccination that was not donated. **Mass immunizers must provide the Medicare beneficiary with a record of the influenza vaccination.**

Additional Billing Guidelines for Non-Traditional Providers Billing Influenza Immunizations

Non-traditional providers and suppliers such as drug stores, senior centers, shopping malls, and self-employed nurses may bill a Medicare carrier/AB MAC for influenza vaccinations if the provider meets State licensure requirements to furnish and administer influenza vaccinations. Providers and suppliers should contact their local Medicare carrier/AB MAC provider enrollment department to enroll in the Medicare Program.

A registered nurse/pharmacist employed by a physician may use the physician's provider number if the nurse/pharmacist, in a location other than the physician's office, provides influenza vaccinations. If the nurse/pharmacist is not working for the physician when the services are provided (e.g., a nurse/pharmacist is "moonlighting," administering influenza vaccinations at a shopping mall at his or her own direction and not that of the physician), the nurse/pharmacist may obtain a provider number and bill the carrier/AB MAC directly. However, if the nurse/pharmacist is working for the physician when the services are provided, the nurse/pharmacist would use the physician's provider number.

The following providers of services may bill Fiscal Intermediaries (FIs)/AB MACS for influenza virus vaccines:

- Hospitals
- Skilled Nursing Facilities (SNFs)
- Critical Access Hospitals (CAHs)
- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Independent Renal Dialysis Facilities (RDFs)
- Hospital RDFs
- Indian Health Service (IHS)/Tribally owned and/or operated hospitals and hospital-based facilities

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS code for the administration of the influenza virus vaccine (G0008), the CPT code for the influenza virus vaccine (90655, 90656, 90657, 90658, or 90660), and the corresponding ICD-9-CM diagnosis code (V04.81, V06.6) in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code for the administration of the influenza virus vaccine (G0008), the CPT code for the influenza virus vaccine (90655, 90656, 90657, 90658, or 90660), the appropriate revenue code (0636, 0771), and the corresponding ICD-9-CM diagnosis code (V06.6, V04.81) in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Additional Coverage Guidelines for Billing for Influenza Immunizations

Home Health Agencies (HHAs)

Medicare will not pay for a skilled nursing visit by an HHA nurse under the home health benefit when the sole purpose for an HHA visit is to administer a vaccine (influenza virus, pneumococcal, or hepatitis B). However, the vaccine and its administration are covered under the home health benefit. The administration should include charges only for the supplies being used and the cost of the injection. HHAs are not permitted to charge for travel time or other expenses (e.g., gasoline).

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

RHCs and FQHCs follow the guidelines in the Internet-Only-Manual, Pub 100-4, Chapter 9, Section 120, available at http://www.cms.hhs.gov/manuals on the CMS website. RHCs and FQHCs do not include charges for the influenza virus vaccine or its administration on the HIPAA 837 Institutional electronic claim format (or Form CMS-1450). Payment for the vaccine is made via the cost report at cost settlement.

Types of Bills for FIs/AB MACs

FIs/AB MACs will reimburse for influenza virus vaccination services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 3:

Table 3 – Facility Types, Types of Bills, and Revenue Codes for Influenza Virus Vaccination

Facility Type	Type of Bill	Revenue Code
Hospital, other than Indian Health Services (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	0636 – vaccine 0771 - administration
IHS Hospital	12X, 13X	0636 – vaccine 0771 - administration
IHS CAH	12X, 85X	0636 – vaccine 0771 - administration
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0636 – vaccine 0771 - administration
SNF Outpatient	23X	0636 – vaccine 0771 - administration
Home Health Agency (HHA)	34X	0636 – vaccine 0771 - administration
Independent and Hospital based Renal Dialysis Facility (RDF)	72X	0636 – vaccine 0771 - administration
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0636 – vaccine 0771 - administration
CAH Method I and II	12X, 85X	0636 – vaccine 0771 - administration

NOTE: RHCs and FQHCs are not included in this table since they do not submit charges for an influenza virus vaccination on a claim. Charges are included in the cost report.

Special Billing Instructions

- Other Charges - Other charges may be listed on the same bill; however, the Medicare provider must include the applicable codes for the additional charges.
- Certified Part A Providers - With the exception of hospice providers, certified Part A providers must bill the FI/AB MAC for this Part B benefit.
- Hospice Providers - Hospice providers bill the carrier/AB MAC using the HIPAA 837 Professional electronic claim format (or Form CMS-1500).
- Non-Medicare Participating Providers - Non-Medicare participating provider facilities bill the local carrier/AB MAC.
- HHAs - HHAs that have a Medicare-certified component and a non-Medicare certified component may elect to furnish the influenza benefit through the non-certified component and bill the carrier/AB MAC.
- Hospitals - Hospitals bill the FI/AB MAC for inpatient vaccination.
- RHCs and FQHCs – Independent and provider-based RHCs and FQHCs do not include charges for the influenza virus vaccine and its administration on the claim. Providers report charges for the influenza virus vaccine and its administration on the cost report. If there is a qualifying visit in addition to the vaccine administration, the RHC/FQHC bills for the visit without adding the cost of the influenza virus vaccine and its administration to the charge for the visit on the claim.
- Dialysis Patients - On claims, for a dialysis patient of a hospital or hospital-based renal dialysis facility, the hospital bills the FI/AB MAC.

Reimbursement Information

General Information

Section 114 of the Benefits Improvement and Protection Act (BIPA) of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, effective for claims with dates of service on or after February 1, 2001, all Medicare providers of the influenza virus vaccine must accept assignment for the **vaccine**. It is not mandatory for providers of the influenza virus vaccine to accept assignment for the **administration** of the vaccine. However, a Medicare provider must accept assignment of both the vaccine and the administration of the vaccine if a provider is enrolled as a provider type "Mass Immunization Roster Biller," submits roster bills, or participates in the centralized billing program. (Refer to the Mass Immunizers/Roster Billers and Centralized Billing sections of this chapter for more information.)

- A physician, provider, or supplier may not collect payment for an immunization from a beneficiary and instruct the beneficiary to submit the claim to Medicare for payment. Medicare law requires that the physicians, providers, and suppliers submit a claim for services to Medicare on the beneficiary's behalf.
- Medicare will pay two administration fees if a beneficiary receives both the influenza virus and the pneumococcal vaccines on the same day.
- HCPCS code G0008 (administration of influenza virus vaccine) may be paid in addition to other services, including E/M services, and is NOT subject to rebundling charges.

- When a physician sees a beneficiary for the sole purpose of administering the influenza virus vaccine, the physician may NOT routinely bill for an office visit. However, if the physician provides services constituting an "office visit" level of service, the physician may bill for an office visit in addition to the influenza virus vaccine and administration. Medicare will pay for the office visit in addition to the vaccine and administration if it is reasonable and medically necessary.
- Medicare providers enrolled as a Mass Immunization Roster Biller must roster bill and accept assignment on both the administration and the vaccine. Refer to the Roster Billing section of this chapter for more information on this type of billing.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for the administration of the influenza virus vaccine is linked to payment for services under the Medicare Physician Fee Schedule (MPFS), but is not actually paid under the MPFS. The charge for the administration is the lesser of the actual charge, or the Fee Schedule amount for a comparable injection. Since Fee Schedules are adjusted for each Medicare payment locality, payment for the administration of the vaccine varies by locality.

> Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Participating Providers

- Participating institutional providers and physicians, providers, and suppliers that accept assignment must bill Medicare if they charge a fee to pay any or all costs related to the provision and/or administration of the influenza virus vaccine. They may not collect payment from beneficiaries.

Non-participating Providers

- Physicians, providers, and suppliers who do not accept assignment may never advertise the service as free since the beneficiary may incur an out-of-pocket expense after Medicare has paid 100 percent of the Medicare-allowed amount.
- Non-participating physicians, providers, and suppliers who do not accept assignment on the **administration** of the vaccine may collect payment from the beneficiary, but they **must submit an unassigned claim on the beneficiary's behalf**. All physicians, qualified non-physician practitioners, and suppliers must accept assignment for the Medicare vaccine payment rate and may not collect payment from the beneficiary for the **vaccine**.
- The limiting charge provision does not apply to the influenza virus vaccine benefit. Non-participating physicians and suppliers who do not accept assignment for the administration of the influenza virus vaccine may collect their usual charges (i.e., the amount charged to a patient who is not a Medicare beneficiary) for the **administration** of the vaccine. **However, all physicians and suppliers, regardless of participation status, must accept assignment of the Medicare vaccine payment rate and may not collect payment from the beneficiary.** When non-participating physicians or suppliers provide the services, the beneficiary is responsible for paying the difference between what the physician or supplier charges and the amount Medicare allows for the **administration** fee.
- The five percent payment reduction for physicians who do not accept assignment does not apply to the administration of the influenza virus vaccine. Only items and services covered under the limiting charge are subject to the five percent payment reduction.

No Legal Obligation to Pay

- Non-Governmental Entities – Non-government entities (providers, physicians, suppliers) that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. For example, Medicare may not pay for influenza virus vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees.

  Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients.

  When an employer offers free vaccinations to its employees, the employer must also offer the free vaccination to an employee who is also a Medicare beneficiary. The employer does not does not have to offer free vaccinations to its non-Medicare employees.

  However, non-governmental entities that do not charge patients who are unable to pay, or reduce their charge for patients of limited means (sliding fee scale), but do expect to be paid if a patient has health insurance that covers the services provided, may bill Medicare and expect payment.

- State and Local Government Entities – Governmental entities such as public health clinics may bill Medicare for influenza virus vaccine administered to Medicare beneficiaries when services are provided free of charge to non-Medicare patients.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for the influenza virus **vaccine** is dependent upon the type of facility. Table 4 lists the type of payment that facilities receive for the influenza virus vaccine:

Table 4 – Facility Types, Types of Bills, and Payment for Influenza Virus Vaccine

Facility	Type of Bill	Payment
Hospital, other than Indian Health Services (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Reasonable cost
IHS Hospital	12X, 13X, 83X	95% of Average Wholesale Price (AWP)
IHS CAH	85X	95% of AWP
CAH Method I and Method II	85X	Reasonable cost
Skilled Nursing Facility (SNF)	22X, 23X	Reasonable cost
Home Health Agency	34X	Reasonable cost
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	95% of AWP
Independent Renal Dialysis Facility (RDF)	72X	95% of AWP
Hospital-based RDF	72X	Reasonable cost

Reimbursement for the **administration** of the influenza virus vaccine is dependent upon the type of facility. Table 5 lists the type of payment that facilities receive for the administration of the influenza virus vaccine:

Table 5 – Facility Types, Types of Bills, and Payment for Administration of Influenza Virus Vaccine

Facility	Type of Bill	Payment
Hospital, other than Indian Health Services (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS 94% of submitted charges for Maryland hospitals under the jurisdiction of the Health Services Cost Review Commission (HSCRC)
IHS Hospital	12X, 13X, 83X	Medicare Physician Fee Schedule (MPFS) as indicated in guidelines below
IHS CAH	85X	MPFS as indicated in guidelines below
CAH Method I and Method II	85X	Reasonable cost
Skilled Nursing Facility (SNF)	22X, 23X	MPFS as indicated in guidelines below
Home Health Agency (HHA)	34X	OPPS
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	*See note and chart below
Independent Renal Dialysis Facility (RDF)	72X	MPFS as indicated in guidelines below
Hospital-based RDF	72X	Reasonable cost

***NOTE:** Payment for vaccines provided in a CORF is 95% of AWP. However, Medicare bases payment for the administration of the vaccine on the MPFS associated with CPT code 90782 for claims with dates of service prior to March 1, 2003, or CPT code 90471 for claims with dates of service on or after March 1, 2003. Effective July 1, 2008, HCPCS code G0128 should no longer be used for billing the vaccine administration in the CORF setting.

Guidelines for Pricing Influenza Virus Vaccine Administration Under the MPFS

Make reimbursement based on the rate in the MPFS associated with the CPT code 90782 or 90471 as follows:

Table 6 – Payment Guidelines for Influenza Virus Vaccine Administration

HCPCS code	Effective prior to March 1, 2003	Effective on and after March 1, 2003
G0008	90782	90471

Reasons for Claim Denial

An example of a situation where Medicare may deny coverage of influenza virus vaccination is when a beneficiary requests more than one influenza virus vaccination during the same influenza season and the Medicare provider cannot justify the medical necessity of the second vaccination.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Medicare providers can obtain additional information about claims from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Pneumococcal Vaccine

Pneumococcal disease is an infection caused by the bacteria Streptococcus pneumoniae, also known as pneumococcus. The most common types of infections caused by this bacterium include middle ear infections, pneumonia, blood stream infections (bacteremia), sinus infections, and meningitis. Invasive pneumococcal infection kills thousands of people in the United States each year, most of them 65 years of age or older. While influenza viruses generally strike during the winter months, pneumococcal disease occurs year round. The pneumococcal vaccine is very good at protecting adults against invasive pneumococcal disease and preventing severe illness, hospitalization, and death. Medicare provides coverage of the pneumococcal vaccine and its administration for all Medicare beneficiaries regardless of risk for the disease.

Risk Factors for Pneumococcal Infection

Anyone can get pneumococcal disease but some individuals are considered to be at high risk for pneumococcal disease or its complications. This group includes:

- Individuals age 65 and older;
- Individuals who have chronic illness such as heart, lung (not including asthma), and kidney disease, diabetes, and alcoholism;

- Individuals with weak immune systems due to cancer, leukemia, and Hodgkin's disease; Human Immunodeficiency Virus (HIV); persons with sickle cell disease or without a functioning spleen;
- Alaskan Natives or individuals from certain Native American populations; and
- Residents of chronic or long-term care facilities.

NOTE: All individuals 65 years of age and older should get both the influenza virus and pneumococcal vaccinations.

Coverage Information

Coverage of pneumococcal polysaccharide vaccine (PPV) and its administration was added to the Medicare Program on July 1, 1981. Coverage of pneumococcal conjugate vaccine and its administration was added to the Medicare Program on January 1, 2008.

Medicare provides coverage of pneumococcal vaccination once in a lifetime generally for all Medicare beneficiaries. (The beneficiary should not have received the pneumococcal vaccine within the last five years.) Medicare may provide coverage of additional vaccinations based on risk or uncertainty of beneficiary pneumococcal status. (Refer to "Revaccination" below).

- Those administering the vaccine should not require the beneficiary to show their immunization record prior to receiving the pneumococcal vaccine, nor is it necessary to review the beneficiary's complete medical record if it is not available.
- If the beneficiary is competent, it is acceptable to rely on the beneficiary's verbal history to determine the beneficiary's prior vaccination status.
- If the beneficiary is uncertain about their vaccination history for the past five years, the vaccine should be administered.
- If the beneficiary is certain of being vaccinated within the last five years, the vaccine should not be administered.
- If the beneficiary is certain of being vaccinated and that more than five years have passed since receipt of the previous dose, revaccination is not appropriate unless the beneficiary is considered to be at highest risk.

Effective for claims with dates of service on or after July 1, 2000, Medicare no longer requires the pneumococcal vaccine to be administered under a physician's order or supervision. Therefore, the beneficiary may receive the vaccine upon request without a physician's order. A physician is not required to be present during the vaccination for the beneficiary to receive coverage under Medicare. However, the law in individual States may require a physician's presence, a physician's order, or other physician involvement.

Medicare provides coverage of the pneumococcal immunization as a Medicare Part B benefit. If the beneficiary receives the service from a Medicare-enrolled participating physician, the beneficiary will pay nothing for the immunization (there is no deductible and no coinsurance or copayment for this benefit).

NOTE: Effective for claims with dates of service on or after January 1, 2008, Medicare provides coverage of pediatric pneumococcal vaccine, Current Procedural Terminology (CPT) code 90669.

Revaccination

Pneumococcal vaccine is typically administered to adults once in a lifetime. However, revaccination may be appropriate for beneficiaries at highest risk for pneumococcal disease and those most likely to have rapid declines in antibody levels. This group includes individuals with the following conditions:

- Functional or anatomic asplenia (e.g., from sickle cell disease, splenectomy);
- Human Immunodeficiency Virus (HIV) infection;
- Leukemia;
- Lymphoma;
- Hodgkin's disease;
- Multiple myeloma;
- Generalized malignancy;
- Chronic renal failure;
- Nephrotic syndrome; and
- Other conditions associated with immunosuppression, such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy, including long-term corticosteroids.

NOTE: If a beneficiary, who is not at highest risk, is revaccinated because of uncertainty about his or her pneumococcal vaccination status, Medicare will pay for the pneumococcal revaccination. Routine revaccinations of beneficiaries 65 or older who are not at highest risk are not appropriate.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes listed in Table 7 to report pneumococcal vaccination services. Providers may list charges for other services on the same bill as the pneumococcal vaccine; however, the applicable codes for the additional services must be used.

Table 7 – HCPCS/CPT Codes for Pneumococcal Vaccines and Administration

HCPCS/CPT Code	Code Descriptor
90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
G0009	Administration of pneumococcal vaccine

Diagnosis Requirements

When a Medicare provider files a claim, they must report the appropriate diagnosis code. If the **sole** purpose of the visit was to receive the pneumococcal vaccine, or if the pneumococcal vaccine is the only service billed on a claim, the provider must report diagnosis code V03.82.

However, if the purpose of the visit was to receive both the pneumococcal and influenza virus vaccine, providers must report diagnosis code V06.6. The ICD-9-CM codes and descriptors are listed in Table 8:

Table 8 – Diagnosis Codes for Pneumococcus

ICD-9-CM Diagnosis Code	Code Descriptor
V03.82	Need for prophylactic vaccination and inoculation against bacterial diseases; other specified vaccinations against single bacterial diseases; Streptococcus pneumoniae (pneumococcus)
V06.6	Need for prophylactic vaccination and inoculation against combinations of diseases; Streptococcus pneumoniae (pneumococcus) and influenza

Billing Requirements

General Requirements

- All billers using the HIPAA 837 Institutional electronic claim format (or Form CMS-1450) and the HIPAA 837 Professional electronic claim format (or Form CMS-1500) should note that all data fields that are required for any institutional or professional claim are required for vaccines and their administration. Medicare providers should bill in accordance with the instructions within provider manuals provided by the Medicare carrier/AB MAC. Additionally, coding specific to these benefits is required.
- Medicare providers are responsible for filling out required items on the claims forms with correct information obtained from the beneficiary. If roster billing for the pneumococcal vaccine, the Medicare provider should ensure that key data elements, such as "Date of Birth", provide sufficient beneficiary information for the contractor to resolve incorrect Health Insurance Claim Numbers (HICNs). However, if through other information on the claim or through beneficiary contact the contractor cannot resolve the problem, the claim will be rejected. For more information on roster billing, see the Mass Immunizers/Roster Billers section later in this chapter.
- Medicare does not pay solely for counseling and education for pneumococcal vaccinations. If a physician provides Medicare-covered services during the visit in which the immunization is given, the physician may code and bill those other medically necessary services, including Evaluation and Management (E/M) services. More information about Documentation Guidelines for Evaluation and Management Services is available at http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS website.
- Since the pneumococcal vaccine benefit does not require any beneficiary coinsurance or deductible, a Medicare beneficiary has a right to receive this benefit without incurring any out-of-pocket expense.

- In addition, the entity that furnishes the vaccine and the entity that administers the vaccine are each required by law to submit a claim to Medicare on behalf of the beneficiary. The entity may bill Medicare for the amount not subsidized from its budget. For example, an entity that incurs a cost of $7.50 per pneumococcal vaccination and pays $2.50 of the cost from its budget may bill the carrier/AB MAC the $5.00 cost that is not paid out of its budget.
- When an entity receives donated pneumococcal vaccine or receives donated services for the administration of the vaccine, the provider may bill Medicare for the portion of the vaccination that was not donated. **Mass immunizers must provide the Medicare beneficiary with a record of the pneumococcal vaccination.**

With the exception of hospice providers, certified institutional providers must bill the FI/AB MAC for this Part B benefit. Hospice providers bill the carrier/AB MAC using the HIPAA 837 Professional electronic claim format (or Form CMS-1500). Non-Medicare participating provider facilities bill the local carrier/AB MAC. HHAs that have a Medicare-certified component and a non-Medicare certified component might elect to furnish the pneumococcal vaccine benefit through the non-certified component and bill the carrier/AB MAC.

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS code for the administration of the pneumococcal vaccine (G0009), the appropriate CPT code for the vaccine, and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Additional Billing Guidelines for Non-Traditional Providers Billing Pneumococcal Immunizations

Non-traditional providers and suppliers such as drug stores, senior centers, shopping malls, and self-employed nurses may bill a Medicare carrier/AB MAC for pneumococcal vaccinations if the provider meets State licensure requirements to furnish and administer pneumococcal vaccinations. Providers and suppliers should contact their local carrier/AB MAC provider enrollment department to enroll in the Medicare Program.

A registered nurse/pharmacist employed by a physician may use the physician's provider number if the nurse/pharmacist, in a location other than the physician's office, provides pneumococcal vaccinations. If the nurse/pharmacist is not working for the physician when the services are provided (e.g., a nurse/pharmacist is "moonlighting," administering pneumococcal vaccinations at a shopping mall at his or her own direction and not that of the physician), the nurse/pharmacist may obtain a provider number and bill the carrier/AB MAC directly. However, if the nurse/pharmacist is working for the physician when the services are provided, the nurse/pharmacist would use the physician's provider number.

The following providers of services may bill FIs/AB MACs for pneumococcal vaccinations:

- Hospitals
- Skilled Nursing Facilities (SNFs)
- Critical Access Hospitals (CAHs)
- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Independent Renal Dialysis Facilities (RDFs)
- Hospital-based RDFs
- Indian Health Service (IHS)/Tribally owned and/or operated hospitals and hospital-based facilities

Billing for Additional Services

If the sole purpose for the office visit is for the administration of the pneumococcal vaccine, a physician may not routinely bill for an office visit. However, if a physician provides services constituting an "office visit" level of service, the physician may bill an office visit in addition to the pneumococcal vaccine and administration. Medicare will pay for the visit in addition to the vaccine and administration if it is reasonable and medically necessary.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code for the administration of the pneumococcal vaccine (G0009), the appropriate CPT code for the vaccine, the appropriate revenue codes (0636, 0771), and the corresponding diagnosis code (V03.82, V06.6) in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Additional Coverage Guidelines for Billing for Pneumococcal Immunizations

Home Health Agencies (HHAs)

Medicare will not pay for a skilled nursing visit by an HHA nurse under the home health benefit when the sole purpose for an HHA visit is to administer a vaccine (influenza virus, pneumococcal, or hepatitis B). However, the vaccine and its administration are covered under the home health benefit. The administration should include charges only for the supplies being used and the cost of the injection. HHAs are not permitted to charge for travel time or other expenses (e.g., gasoline).

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

RHCs and FQHCs follow the guidelines in the Internet-Only-Manual, Pub 100-4, Chapter 9, Section 120, available at http://www.cms.hhs.gov/manuals on the CMS website. RHCs and FQHCs do not include charges for the pneumococcal vaccine or its administration on the HIPAA 837 Institutional electronic claim format (or Form CMS-1450). Payment for the vaccine is made via the cost report at cost settlement.

Types of Bills for FIs/AB MACs

FIs/AB MACs will reimburse for pneumococcal vaccination services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 9:

Table 9 – Facility Types, Types of Bills, and Revenue Codes for Pneumococcal Vaccination

Facility Type	Type of Bill	Revenue Code
Hospital, other than Indian Health Services (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	0636 – vaccine 0771 - administration
IHS Hospital	12X, 13X, 83X	0636 – vaccine 0771 - administration
IHS CAH	85X	0636 – vaccine 0771 - administration
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0636 – vaccine 0771 - administration
SNF Outpatient	23X	0636 – vaccine 0771 - administration
Home Health Agency (HHA)	34X	0636 – vaccine 0771 - administration
Independent and Hospital-based Renal Dialysis Facility (RDF)	72X	0636 – vaccine 0771 - administration
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0636 – vaccine 0771 - administration
CAH Method I and II	85X	0636 – vaccine 0771 - administration

NOTE: RHCs and FQHCs are not included in this table since they do not submit charges for a pneumococcal vaccination on a claim. Charges are included in the cost report.

Special Billing Information

- Other Charges - Other charges may be listed on the same bill; however, the Medicare provider must include the applicable codes for the additional charges.
- Hospice Providers - Hospice providers bill the carrier/AB MAC using the HIPAA 837 Professional electronic claim format (or Form CMS-1500).
- Hospitals - Hospitals bill the FI/AB MAC for inpatient vaccination.
- RHCs and FQHCs – Independent and provider-based RHCs and FQHCs do not include charges for the pneumococcal vaccine and its administration on the claim. Providers report charges for the pneumococcal vaccine and its administration on the cost report. If there is a qualifying visit in addition to the vaccine administration, the RHC/FQHC bills for the visit without adding the cost of the pneumococcal vaccine and its administration to the charge for the visit on the claim.
- Dialysis Patients - On claims, regardless of where pneumococcal vaccine is administered to a dialysis patient of a hospital or hospital-based renal dialysis facility, the hospital bills the FI/AB MAC.

Reimbursement Information

General Information

Section 114 of the Benefits Improvement and Protection Act (BIPA) of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, effective for claims with dates of service on or after February 1, 2001, all providers of the pneumococcal vaccine must accept assignment for the **vaccine**. It is not mandatory for providers of the pneumococcal vaccine to accept assignment for the **administration** of the vaccine. However, a Medicare provider must accept assignment of both the vaccine and the administration of the vaccine if a provider is enrolled as provider type "Mass Immunization Roster Biller," submits roster bills, or participates in the centralized billing program. (Refer to the Mass Immunizers/Roster Billers and Centralized Billing sections of this chapter for more information.)

> See the National Correct Coding Initiative Edits web page for currently applicable bundled carrier processed procedures at http://www.cms.hhs.gov/NationalCorrectCodInitEd on the CMS website.

- A physician, provider, or supplier may not collect payment for an immunization from a beneficiary and instruct the beneficiary to submit the claim to Medicare for payment. Medicare law requires that physicians, providers, and suppliers submit a claim for services to Medicare on the beneficiary's behalf.
- Medicare will pay two administration fees if a beneficiary receives both the influenza virus and the pneumococcal vaccine on the same day.
- HCPCS code G0009 (administration of pneumococcal vaccine) may be paid in addition to other services, including E/M services and is NOT subject to rebundling charges.
- When a physician sees a beneficiary for the sole purpose of administering the pneumococcal vaccine, he or she may NOT routinely bill for an office visit. However, if a beneficiary actually receives other services constituting an "office visit" level of service, the physician may bill for a visit and Medicare will pay for the visit if it is reasonable and medically necessary.
- Medicare providers enrolled as Mass Immunization Roster Billers must roster bill and accept assignment on both the administration and the vaccine. Refer to the Roster Billing section in this chapter for more information on this type of billing.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare payment by carriers/AB MACs for the administration of the pneumococcal vaccine is linked to payment for services under the Medicare Physician Fee Schedule (MPFS), but is not actually paid under the MPFS. The charge for the administration is the lesser of the actual charge or the Fee Schedule amount for a comparable injection. Since Fee Schedules are adjusted for each Medicare payment locality, payment for the administration of the vaccine varies by locality.

> Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Participating Providers

- Participating institutional providers and physicians, providers, and suppliers that accept assignment must bill Medicare if they charge a fee to pay any or all costs related to the provision and/or administration of the pneumococcal vaccine. They may not collect payment from beneficiaries.

Non-participating Providers

- Physicians, providers, and suppliers who do not accept assignment may never advertise the service as free since the beneficiary incurs an out-of-pocket expense after Medicare has paid 100 percent of the Medicare-allowed amount.
- Non-participating physicians, providers, and suppliers who do not accept assignment on the **administration** of the vaccine may collect payment from the beneficiary, but they **must submit an unassigned claim on the beneficiary's behalf**. All physicians, qualified non-physician practitioners, and suppliers must accept assignment for the Medicare vaccine payment rate and may not collect payment from the beneficiary for the **vaccine**.
- The limiting charge provision does not apply to the pneumococcal vaccine benefit. Non-participating physicians and suppliers that do not accept assignment for the administration of the pneumococcal vaccine may collect their usual charges (i.e., the amount charged to a beneficiary who is not a Medicare beneficiary) for the **administration** of the vaccine. **However, all physicians and suppliers, regardless of participation status, must accept assignment of the Medicare vaccine payment rate and may not collect payment from the beneficiary for the vaccine.** When a non-participating physician or supplier provides the services, the beneficiary is responsible for paying the difference between what the physician or supplier charges and the amount Medicare allows for the **administration** fee.
- The five percent payment reduction for physicians who do not accept assignment does not apply to the administration of the pneumococcal vaccine. Only items and services covered under limiting charge are subject to the five percent payment reduction.

No Legal Obligation to Pay

- Non-Governmental Entities – Non-government entities (providers, physicians, suppliers) that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare.

  Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients.

  When an employer offers free vaccinations to its employees, the employer must also offer the free vaccination to an employee who is also a Medicare beneficiary. The employer does not have to offer free vaccinations to its non-Medicare employees.

  However, non-governmental entities that do not charge patients who are unable to pay, or reduce their charge for patients of limited means (sliding fee scale), but do expect to be paid if a patient has health insurance that covers the services provided, may bill Medicare and expect payment.
- State and Local Government Entities – Government entities such as public health clinics may bill Medicare for the pneumococcal vaccine administered to Medicare beneficiaries when services are provided free of charge to non-Medicare patients.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for the pneumococcal **vaccine** is dependent upon the type of facility. Table 10 lists the type of payment that facilities receive for the pneumococcal vaccine:

Table 10 – Facility Types, Types of Bills, and Payment for Pneumococcal Vaccine

Facility	Type of Bill	Payment
Hospital, other than Indian Health Services (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Reasonable cost
IHS Hospital	12X, 13X, 83X	95% of Average Wholesale Price (AWP)
IHS CAH	85X	95% of AWP
CAH Method I and Method II	85X	Reasonable cost
Skilled Nursing Facility (SNF)	22X, 23X	Reasonable cost
Home Health Agency (HHA)	34X	Reasonable cost
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	95% of AWP
Independent Renal Dialysis Facility (RDF)	72X	95% of AWP
Hospital-based RDF	72X	Reasonable cost

Reimbursement for the **administration** of the pneumococcal vaccine is dependent upon the type of facility. Table 11 lists the type of payment that facilities receive for the administration of the pneumococcal vaccine:

Table 11 – Facility Types, Types of Bills, and Payment for Administration of Pneumococcal Vaccine

Facility	Type of Bill	Payment
Hospital, other than Indian Health Services (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS 94% of submitted charges for Maryland Hospitals under the jurisdiction of the Health Services Cost Review Commission (HSCRC)
IHS Hospital	12X, 13X, 83X	Medicare Physician Fee Schedule (MPFS) as indicated in guidelines below
IHS CAH	85X	MPFS as indicated in guidelines below
CAH Method I and Method II	85X	Reasonable cost
Skilled Nursing Facility (SNF)	22X, 23X	MPFS as indicated in guidelines below
Home Health Agency (HHA)	34X	OPPS
Comprehensive Outpatient Rehabilitation Facility (CORF)*	75X	*See note and chart below
Independent Renal Dialysis Facility (RDF)	72X	MPFS as indicated in guidelines below
Hospital-based RDF	72X	Reasonable cost

***NOTE:** Payment for vaccines provided in a CORF is 95% of AWP. However, Medicare bases payment for the administration of the vaccine on the MPFS associated with CPT code 90782 for claims with dates of service prior to March 1, 2003, or CPT code 90471 for claims with dates of service on or after March 1, 2003. Effective July 1, 2008, HCPCS code G0128 should no longer be used for billing the vaccine administration in the CORF setting.

Guidelines for Pricing Pneumococcal Vaccine Administration Under the MPFS

Make reimbursement based on the rate in the MPFS associated with the CPT code 90782 or 90471 as follows:

Table 12 – Payment Guidelines for Pneumococcal Vaccine Administration

HCPCS code	Effective prior to March 1, 2003	Effective on and after March 1, 2003
G0009	90782	90471

Reasons for Claim Denial

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Hepatitis B Virus (HBV) Vaccine

Hepatitis B is a serious disease caused by the hepatitis B virus (HBV). The virus can affect people of all ages. Hepatitis B attacks the liver and can cause chronic (life-long) infection, resulting in cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. The virus is found in the blood and body fluids of infected people and can be spread through sexual contact, the sharing of needles and other drug paraphernalia, razors, tattoos, body piercing, from a mother to her infant during birth, and by living in a household with a chronically infected person. Hepatitis B can be prevented with the vaccine. Medicare provides coverage of the hepatitis B vaccine and its administration for certain beneficiaries at intermediate to high risk for HBV.

Dosage Information

Scheduled doses of the hepatitis B vaccine are required to provide complete protection to an individual.

Risk Factors for Hepatitis B Infection

Medicare provides coverage for certain beneficiaries at high or intermediate risk for HBV infection.

Vaccination is recommended for the following high risk groups:

- Individuals with End-Stage Renal Disease (ESRD),
- Individuals with hemophilia who received Factor VIII or IX concentrates,
- Clients of institutions for the mentally handicapped,
- Persons who live in the same household as an HBV carrier,
- Homosexual men, and
- Illicit injectable drug users.

Vaccination is recommended for the following intermediate risk groups:

- Staff in institutions for the mentally handicapped, and
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

Exception: Persons in the above-listed groups would not be considered at high or intermediate risk of contracting HBV infection if they have laboratory evidence positive for antibodies to HBV (ESRD patients are routinely tested for HBV antibodies as part of their continuing monitoring and therapy).

Coverage Information

Coverage of the hepatitis B vaccine and its administration was added to the Medicare Program in 1984. Medicare provides coverage for the hepatitis B vaccine and its administration for beneficiaries at high or intermediate risk of contracting HBV. Medicare requires that the hepatitis B vaccine be administered under a physician's order with supervision.

Medicare provides coverage for the hepatitis B vaccine as a Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes listed in Table 13 are used to report hepatitis B vaccination services:

Table 13 – HCPCS/CPT Codes for HBV Vaccine and Administration

HCPCS/CPT Code	Code Descriptor
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
G0010*	Administration of Hepatitis B vaccine
90471*	Immunization Administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) (Do not report 90471 in conjunction with 90473)

HCPCS/CPT Code	Code Descriptor
90472*	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) (Use 90472 in conjunction with 90471 or 90473)

***NOTE:** For claims with dates of service prior to January 1, 2006, Outpatient Prospective Payment System (OPPS) and non-OPPS hospitals report HCPCS code G0010 for hepatitis B vaccine administration. For claims with dates of service of January 1, 2006 and later, OPPS hospitals report CPT codes 90471 or 90472 for hepatitis B vaccine administration as appropriate in place of G0010.

Diagnosis Requirements

When a Medicare provider files a claim, they must report the appropriate diagnosis code. If the **sole** purpose of the visit was to receive the hepatitis B vaccine or if the hepatitis B vaccine is the only service billed on a claim, diagnosis code V05.3 must be reported. The ICD-9-CM code and descriptor is listed in Table 14:

Table 14 – Diagnosis Code for Hepatitis B Vaccination

ICD-9-CM Diagnosis Code	Code Descriptor
V05.3	Need for prophylactic vaccination and inoculation against single diseases; Viral hepatitis

Billing Requirements

General Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare still requires that the hepatitis B vaccination be administered under a physician's order with supervision. Because of this continuing requirement, the ordering and/or referring physician information must be reported on the claim. In addition, when physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS code for the administration of the hepatitis B vaccine (G0010), the CPT vaccine code (90740, 90743, 90744, 90746, 90747), the appropriate revenue code, and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code for the administration of the hepatitis B vaccine (G0010), the CPT vaccine code (90740, 90743, 90744, 90746, 90747), the appropriate revenue codes (0636, 0771), and the corresponding diagnosis code (V05.3) in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Additional Coverage Guidelines for Billing for Hepatitis B Immunizations

Home Health Agencies (HHAs)

Medicare will not pay for a skilled nursing visit by an HHA nurse under the home health benefit when the sole purpose for an HHA visit is to administer a vaccine (hepatitis B, influenza virus, or pneumococcal). However, the vaccine and its administration are covered under the vaccine benefit. The administration should include charges only for the supplies being used and the cost of the injection. HHAs are not permitted to charge for travel time or other expenses (e.g., gasoline). A separate bill is not allowed for the visit.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

For independent and provider-based RHCs and FQHCs, payment for the hepatitis B vaccine and its administration are included in the all-inclusive rate. RHCs and FQHCs do not bill for a visit when the only service provided is the administration of the hepatitis B vaccine. If the sole reason for the visit is to receive the hepatitis B vaccine, the cost can be included on a claim for the beneficiary's subsequent visit. If other services, which constitute a qualifying RHC or FQHC visit, are provided at the same time as the hepatitis B vaccination, the cost of the vaccine and its administration are included on the claim for the current visit.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for hepatitis B vaccination services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 15:

Table 15 – Facility Types, Types of Bills, and Revenue Codes for Hepatitis B Vaccination

Facility Type	Type of Bill	Revenue Code
Hospital, other than Indian Health Services (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	0636 – vaccine 0771 - administration
IHS Hospital	12X, 13X, 83X	0636 – vaccine 0771 - administration
IHS CAH	85X	0636 – vaccine 0771 - administration
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0636 – vaccine 0771 - administration
SNF Outpatient	23X	0636 – vaccine 0771 - administration
Home Health Agency (HHA)	34X	0636 – vaccine 0771 - administration
Independent and Hospital-based Renal Dialysis Facility (RDF)	72X	0636 – vaccine 0771 - administration
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0636 – vaccine 0771 - administration
CAH Method I and II	85X	0636 – vaccine 0771 - administration

Special Billing Information

- RHCs and FQHCs – RHCs and FQHCs may only include charges for the hepatitis B vaccine and its administration on a claim when they submit a claim for other services that constitute an RHC or FQHC qualifying visit. All charges for the visit and the hepatitis B vaccine and its administration must be combined on the same line under revenue code 052X. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520.

Reimbursement Information

General Information

Section 114 of the Benefits Improvement and Protection Act (BIPA) of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, effective for claims with dates of service on or after February 1, 2001, all providers of the hepatitis B vaccine must accept assignment for the **vaccine**. It is not mandatory for Medicare providers to accept assignment for the **administration** of the hepatitis B vaccine.

See the National Correct Coding Initiative Edits web page for currently applicable bundled carrier processed procedures at http://www.cms.hhs.gov/NationalCorrectCodInitEd on the CMS website.

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for the vaccine and its administration is paid at 80 percent of the Medicare Physician Fee Schedule (MPFS). Deductible and coinsurance or copayment apply.

No Legal Obligation to Pay

- Non-Governmental Entities – Non-government entities (providers, physicians, suppliers) that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare.

  Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients.

  When an employer offers free vaccinations to its employees, the employer must also offer the free vaccination to an employee who is also a Medicare beneficiary. The employer does not have to offer free vaccinations to its non-Medicare employees.

  However, non-governmental entities that do not charge patients who are unable to pay, or reduce their charge for patients of limited means (sliding fee scale), but do expect to be paid if a patient has health insurance that covers the services provided, may bill Medicare and expect payment.

- State and Local Government Entities – Government entities such as public health clinics may bill Medicare for hepatitis B vaccine administered to Medicare beneficiaries when services are provided free of charge to non-Medicare patients.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for the hepatitis B **vaccine** is dependent upon the type of facility. Table 16 lists the type of payment that facilities receive for the hepatitis B vaccine:

Table 16 – Facility Types, Types of Bills, and Payment for Hepatitis B Vaccine

Facility	Type of Bill	Payment
Hospital, other than Indian Health Services (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Reasonable cost
IHS Hospital	12X, 13X, 83X	95% of Average Wholesale Price (AWP)
IHS CAH	85X	95% of AWP
CAH Method I and Method II	85X	Reasonable cost
Skilled Nursing Facility (SNF)	22X, 23X	Reasonable cost
Home Health Agency (HHA)	34X	Reasonable cost
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	95% of AWP
Independent Renal Dialysis Facility (RDF)	72X	95% of AWP
Hospital-based RDF	72X	Reasonable cost

Reimbursement for the **administration** of the hepatitis B vaccine is dependent upon the type of facility. Table 17 lists the type of payment that facilities receive for the administration of the hepatitis B vaccine:

Table 17 – Facility Types, Types of Bills, and Payment for Hepatitis B Vaccine Administration

Facility	Type of Bill	Payment
Hospital other than Indian Health Services (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS 94% of submitted charges for Maryland hospitals under the jurisdiction of the Health Services Cost Review Commission (HSCRC)
IHS Hospital	12X, 13X, 83X	Medicare Physician Fee Schedule (MPFS) as indicated in the guidelines below

Facility	Type of Bill	Payment
CAH	85X	Reasonable cost
IHS CAH	85X	MPFS as indicated in the guidelines below
Skilled Nursing Facility (SNF)	22X, 23X	MPFS as indicated in the guidelines below
Home Health Agency (HHA)	34X	OPPS
Comprehensive Outpatient Rehabilitation Facility (CORF)*	75X	MPFS as indicated in the guidelines below *See Note below
Independent Renal Dialysis Facility (RDF)	72X	MPFS as indicated in the guidelines below
Hospital-based RDF	72X	Reasonable cost

***NOTE:** Payment for vaccines provided in a CORF is 95% of AWP. However, Medicare bases payment for the administration of the vaccine on the MPFS associated with CPT code 90782 for claims with dates of service prior to March 1, 2003, or CPT code 90471 for claims with dates of service on or after March 3, 2003. Effective July 1, 2008, HCPCS code G0128 should no longer be used for billing the vaccine administration in the CORF setting.

Guidelines for Pricing Hepatitis B Vaccine Administration under the MPFS

Reimbursement is based on the rate in the MPFS associated with CPT code 90782 or 90471 as listed in Table 18 below:

Table 18 – Payment Guidelines for Hepatitis B Vaccine Administration

HCPCS code	Effective prior to March 1, 2003	Effective on and after March 1, 2003
G0010	90782	90471

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of the hepatitis B vaccination:

- The beneficiary is not at intermediate or high risk of contracting HBV.
- The services were not ordered by a doctor of medicine or osteopathy.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

An Advance Beneficiary Notice of Noncoverage (ABN) is a written notice that a Medicare provider or supplier gives to a Medicare beneficiary to inform the beneficiary before he or she receives specified items or services that otherwise might be paid for by Medicare that Medicare probably will not pay on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance.

Frequently, there is confusion regarding whether an ABN can be used to shift liability to a beneficiary for the cost of non-covered items or services. In making this decision, the Medicare provider/supplier first must determine whether the item or service meets the definition of the Medicare-covered benefit. If the item or service does not meet the definitional requirements for the Medicare-covered benefit, then the item or service will never be covered by Medicare. As a result, the beneficiary will always be liable for the cost of the item or service, and an ABN is not needed to shift liability to the beneficiary.

If the item or service meets the definition of the Medicare-covered benefit, Medicare still may not pay for the item or service if the item or service was "not reasonable and necessary" for the beneficiary on the occasion in question or if the item or service exceeds the frequency limitation for the particular benefit or falls outside the applicable time frame for receipt of the covered benefit. In these instances, an ABN, signed by the beneficiary, may be used to shift liability for the cost of the item or service to the beneficiary. If a valid ABN is not issued to the beneficiary, the Medicare provider/supplier may be held liable for the cost of the item or service unless the Medicare provider/supplier is able to demonstrate that they did not know and could not reasonably have been expected to know that Medicare would not pay for the item or service. If this is the case, neither the provider/supplier nor the beneficiary will be held liable for the cost of the item or service.

Mass Immunizers/Roster Billers

What Is a "Mass Immunizer"?

A "mass immunizer," as used by the Centers for Medicare & Medicaid Services (CMS), is defined as a Medicare provider who generally offers influenza virus and/or pneumococcal vaccinations to a large number of individuals; for example, the general public or members of a specific group, such as residents of a retirement community. A mass immunizer may be a traditional Medicare provider or supplier, such as a hospital outpatient department, or may be a non-traditional provider or supplier, such as a senior citizens' center, a public health clinic, community pharmacy, or supermarket. Mass immunizers submit claims for immunizations on roster bills and must accept assignment. Mass immunizer is a provider-type that was created under Medicare specifically to facilitate mass immunization, not to provide other services.

NOTE: Medicare has not developed roster billing for hepatitis B vaccinations.

Enrollment Requirements

This enrollment process currently applies only to entities that enroll with Medicare as a Mass Immunization Roster Biller. These entities will perform the following functions:

(1) Bill a carrier/AB MAC

(2) Use roster bills

(3) Bill only for influenza virus and/or pneumococcal vaccinations

(4) Accept assignment on both the vaccines and their administration

Whether an entity enrolls as a provider type "Mass Immunization Roster Biller" or some other type of provider, the entity must follow all normal enrollment processes and procedures. Authorization from the CMS Central Office (CO) to participate in centralized billing is dependent upon the entity's ability to qualify as some type of Medicare provider.

Medicare providers and suppliers must enroll in the Medicare Program even if mass immunizations are the only service they will provide to Medicare beneficiaries. Entities providing mass immunizations must enroll by filling out Form CMS-855I for individuals or Form CMS-855B for groups. Providers and suppliers who wish to roster bill for mass immunizations should contact the carrier/AB MAC servicing their area for a copy of the enrollment application and instructions for mass immunizers. A list of carriers/AB MACs and their contact information can be found at http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website. The enrollment applications can also be found online at http://www.cms.hhs.gov/MedicareProviderSupEnroll on the CMS website.

Medicare providers and suppliers who wish to bill for other Part B services must enroll as a regular provider or supplier by completing the entire CMS-855I for individuals or the CMS-855B for groups. Although CMS wants to make it as easy as possible for providers and suppliers to immunize Medicare beneficiaries and bill Medicare, it must ensure that those providers who wish to enroll in the Medicare Program are qualified providers, receive a provider ID number, and receive payment.

Form CMS-1500

Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

NOTE: Roster billing is only allowed for influenza virus and pneumococcal vaccinations. Hepatitis B vaccination claims may not be submitted on roster bills.

Roster Billing Procedures

Mass Immunizer Roster Billing

Roster billing is a streamlined process for submitting health care claims for large groups of individuals for influenza virus and/or pneumococcal vaccinations. Roster billing can be done electronically or by paper. Mass immunizers should contact their carrier/AB MAC for information on electronic roster billing.

General Information

Individuals and entities submitting paper claims for influenza virus and pneumococcal vaccinations must submit a separate Form CMS-1450 or Form CMS-1500 for each type of vaccination. Each Form CMS-1450 or Form CMS-1500 must have an attached roster bill listing the beneficiaries who received that type of vaccination. Each roster bill must also contain all other information required on a roster bill.

For inpatient/outpatient departments of hospitals and outpatient departments of other providers that roster bill, a "signature on file" stamp or notation qualifies as an actual signature on the roster claim form if the provider has access to a signature on file in the beneficiary's record. In this situation, the provider is not required to obtain the patient's signature on the roster. A "signature on file" is acceptable for entities that bill Medicare FIs/AB MACs and/or carriers/AB MACs.

Roster Billing and Paper Claims

Paper claims for roster billing of Medicare-covered vaccinations are exempt from the HIPAA electronic billing requirement under a ruling published August 15, 2003. To reference the ruling, please go to http://edocket.access.gpo.gov/2003/pdf/03-20955.pdf on the Web.

Roster Billing Institutional Claims

Generally, for institutional claims (claims submitted to Medicare FIs/AB MACs for processing) only, providers must vaccinate at least five beneficiaries per day to roster bill. However, this requirement is waived for inpatient hospitals that mass immunize and use the roster billing method.

Medicare will pay for both the influenza virus and pneumococcal vaccines above the Diagnosis-Related Group (DRG) rate for patients vaccinated during hospitalization. Hospitals may roster bill for both vaccines using TOB 12X. Vaccines billed on TOB 11X will not be paid. There is no coinsurance or deductible for either vaccine.

Roster Billing Part B Claims

Providers and suppliers submitting Part B claims to carriers/AB MACs for processing are not required to immunize at least five beneficiaries on the same date for an individual or entity to qualify for roster billing. However, the rosters should not be used for single patient bills, and the date of service for each vaccination administered must be entered.

Modified Form CMS-1500 (08-05)

Medicare providers who qualify to roster bill may use a preprinted Form CMS-1500.

The following blocks listed in Table 19 can be preprinted on a modified Form CMS-1500 for entities using roster billing for influenza virus vaccine, pneumococcal, and/or administration claims submitted to carriers/AB MACs:

Table 19 – Preprinted Information on Form CMS-1500

Form CMS-1500 Blocks	Preprinted Information
Item 1:	An X in the Medicare block
Item 2:	(Patient's Name): "SEE ATTACHED ROSTER"
Item 11:	(Insured's Policy Group or FECA Number): "NONE"
Item 20:	(Outside Lab?): An "X" in the "NO" block
Item 21:	(Diagnosis or Nature of Illness): Line 1: Choose appropriate diagnosis code from §10.2.1
Item 24B:	[Place of Service (POS)]: Line 1: "60" Line 2: "60" NOTE: POS code "60" must be used for roster billing.
Item 24D:	(Procedures, Services or Supplies): Line 1: Pneumococcal Vaccine: "90732" or Influenza Virus Vaccine: "Select appropriate influenza virus vaccine code" Line 2: Pneumococcal Vaccine Administration: "G0009" or Influenza Virus Vaccine Administration: "G0008"
Item 24E:	(Diagnosis Code): Line 1 and 2: "1"

Form CMS-1500 Blocks	Preprinted Information
Item 24F:	($ Charges): The entity must enter the charge for each listed service. If the entity is not charging for the vaccine or its administration, it should enter 0.00 or "NC" (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC pneumococcal or influenza virus vaccine claims only if your system is able to accept them.
Item 27:	(Accept Assignment): An "X" in the YES block
Item 29:	(Amount Paid): "$0.00"
Item 31:	(Signature of Physician or Supplier): The entity's representative must sign the modified Form CMS-1500 (08-05).
Item 32:	Enter the name, address, and ZIP Code of the location where the service was provided (including centralized billers).
Item 32a:	Enter the NPI of the service facility as soon as it is available. The NPI may be reported on Form CMS-1500 (08-05) as early as October 1, 2006.
Item 33:	(Physician's, Supplier's Billing Name): The entity must complete this item to include the Provider Identification Number (not the Unique Physician Identification Number) or NPI when required.
Item 33a:	Effective May 23, 2007, and later, enter the NPI of the billing provider or group. [The NPI may be reported on Form CMS 1500 (08-05) as early as October 1, 2006.]

Medicare providers must submit separate Form CMS-1500 claim forms, along with separate roster bills for influenza virus and pneumococcal vaccine roster billing.

Roster Claim Form

Medicare providers must include the following information on a patient roster form that will be attached to a pre-printed Form CMS-1500 under the roster billing procedure:

- Provider name and NPI number,
- Date of service,

NOTE: Although physicians who provide pneumococcal or influenza virus vaccinations may roster bill if they vaccinate fewer than five beneficiaries per day, they must include the individual date of service for each beneficiary's vaccination on the roster form.

- Control number for the contractor,
- Patient's health insurance claim number,
- Patient's name,
- Patient's address,
- Patient's date of birth,

- Patient's sex, and
- Beneficiary's signature or stamped "signature on file".

Some carriers/AB MACs allow providers and suppliers to develop their own roster forms that contain the minimum data listed above, while others do not. Please contact the carrier/AB MAC to learn their particular practice regarding patient roster forms.

NOTE: A stamped "signature on file" qualifies as an actual signature on a roster claim form if the provider has a signed authorization on file to bill Medicare for services provided. In this situation, the provider is not required to obtain the patient signature on the roster, but instead has the option of reporting "signature on file" in lieu of obtaining the patient's actual signature.

Required Language for Pneumococcal Vaccine Rosters

The roster bills used for influenza virus and pneumococcal vaccinations are not identical. The pneumococcal roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering pneumococcal vaccination:

WARNING: Beneficiaries must be asked if they have received a pneumococcal vaccination.

- Rely on patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past five years, administer the vaccine.
- If patients are certain that they have been vaccinated wihin the past five years, do not revaccinate.

Other Covered Services

Medicare providers may not list other covered services with the influenza virus and/or pneumococcal vaccine and administration on the modified Form CMS-1500. Other covered services are subject to more comprehensive data requirements that the roster billing process is not designed to accommodate. Providers must bill other services using normal Medicare Part B claims filing procedures and forms.

Jointly Sponsored Vaccination Clinics

In some instances, two entities, such as a grocery store and a pharmacy, jointly sponsor an influenza virus or pneumococcal vaccination clinic. Assuming that charges are made for the vaccine and its administration, the entity that furnishes the vaccine and the entity that administers the vaccine are each required to submit claims. Both parties **must** file separately for the specific component furnished for which a charge was made.

When billing only for the administration, billers must indicate in block 24 of Form CMS-1500 that they did not furnish the vaccine. For roster billed claims, this can be accomplished by lining through the preprinted item 24 line item component that was not furnished by the billing entity or individual.

Centralized Billing

NOTE: This section applies only to those individuals and entities that will provide mass immunization services for influenza virus and pneumococcal vaccinations and that have been authorized by CMS to centrally bill.

What Is Centralized Billing?

Centralized billing is an optional program available to providers who qualify to enroll with Medicare as provider type "Mass Immunization Roster Biller," as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billing is a process in which a Medicare provider, who is a mass immunizer for influenza virus and pneumococcal immunizations, can send all their influenza virus and pneumococcal claims to a single carrier/AB MAC for payment, regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers, or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the influenza virus and pneumococcal vaccines and their administration. Currently, CMS authorizes only a limited number of Medicare providers to centrally bill for influenza virus and pneumococcal immunization claims.

Centralized billers must roster bill, must accept assignment, and must bill electronically.

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers/AB MACs processing claims. Individuals and entities providing vaccine and administration of vaccine must be properly licensed in the State in which the immunizations are given. It is the responsibility of the provider to make sure they meet the licensure/certification requirements in the States where they plan to operate vaccination clinics.

Payment Rates and Mandatory Assignment

The payment rates for the administration of the vaccinations are based on the Medicare Physician Fee Schedule (MPFS) for the appropriate year. Payments vary based on the geographic locality where the vaccination was performed. The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals, which is the lower of cost or 95 percent of the Average Wholesale Price (AWP).

Section 114 of the Benefits Improvement and Protection Act (BIPA) of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, effective for claims with dates of service on or after February 1, 2001, all providers of pneumococcal and influenza virus vaccines must accept assignment for the vaccine. In addition, as a requirement for centralized billing and roster billing, Medicare providers must also agree to accept assignment for the administration of the vaccines. This means that centralized billers and roster billers must agree to accept the amount that Medicare pays for the vaccine and the administration. Since there is no coinsurance/copayment for the influenza virus and pneumococcal vaccine benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination.

Do I have to enroll as a different provider type to participate in the centralized billing program?

Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the processing carrier/AB MAC for centralized billing through completion of Form CMS-855 (Provider Enrollment Application).

To Participate in the Centralized Billing Program

Individuals and entities interested in centralized billing must contact the CMS Central Office, in writing, at the following address:

The Centers for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop C4-10-07
Baltimore, Maryland 21244

Medicare providers/suppliers are encouraged to apply to enroll as a centralized biller early as the enrollment process takes 8-12 weeks to complete. Applicants who have not completed the entire enrollment process and received approval from the CMS Central Office and the designated carrier/AB MAC to participate as a Medicare mass immunizer centralized biller will not be allowed to submit claims to Medicare for reimbursement.

Required information

The information requested below must be included with the individual or entity's written request to participate in centralized billing:

- Estimates for the number of beneficiaries who will receive influenza virus vaccinations,
- Estimates for the number of beneficiaries who will receive pneumococcal vaccinations,
- The approximate dates for when the vaccinations will be given,
- A list of the States in which influenza virus and pneumococcal vaccination clinics will be held,
- The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse),
- Whether the nurses who will administer the influenza virus and pneumococcal vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza virus and pneumococcal vaccinations,
- Names and addresses of all entities operating under the corporation's application, and
- Contact information for the designated contact person for the centralized billing program.

NOTE: Approval for centralized billing is limited to the 12-month period from September 1 through August 31 of the following year. It is the responsibility of centralized billers to reapply to CMS Central Office for approval each year by June 1.

Can I request payment up front from the beneficiary for the influenza virus and/or pneumococcal vaccination?

The practice of requiring a beneficiary to pay for the vaccination up front and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per §1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment.

Planning a Flu Vaccination Clinic

Planning a Flu Vaccination Clinic is being provided here for informational purposes as a general guide. The issues involved in planning and administering a flu vaccination clinic can be complex and may vary from State to State. We encourage Medicare providers, suppliers, and immunizers to become familiar with relevant laws, regulations, and policies, before planning and administering a flu vaccination clinic.

Table 20 – Flu Vaccination Clinic Calendar

Month	Activity
January	Create a planning committee ▸ Determine roles and responsibilities ▸ Determine staffing levels needed ▸ Decide location(s) of vaccination clinic
February	Hold planning committee meeting ▸ Determine clinic layout and specifications ▸ Determine how to advertise the clinic
March	Hold planning committee meeting ▸ Coordinate with other flu vaccination clinics in geographical area ▸ Gather information on latest vaccine recommendations (visit http://www.cdc.gov/flu on the Web).
April	Order vaccine
May	Determine dates of flu vaccination clinic(s) ▸ Consider conducting flu vaccination clinics in October and/or November; also consider offering a flu vaccination clinic in December or January, even after influenza activity has been documented in your community.
June	Register your flu vaccination clinic on the flu clinic locator website (visit http://www.flucliniclocator.org on the Web)
July	Decide how many nurses and clerks will need to be hired on a temporary basis to administer the shots and submit the claims
August	Send letters/emails to retirement communities, churches, municipal buildings, and other locations throughout the community offering to set up a flu vaccination clinic at their site. For sample letters, visit http://www.flucliniclocator.org on the Web.

Month	Activity
September	Begin advertising flu shot clinic dates, times, and locations. For sample posters, visit http://www.flucliniclocator.org on the Web.
October	Conduct clinics
November	Conduct clinics
December	Conduct clinics
Beyond December	Protection can still be obtained if the flu vaccine is given in December or later. Continue to provide the flu shot as long as you have vaccine available, even after the new year.

Flu Vaccination Clinic Supplies Checklist

Essential items for a flu vaccination clinic include the following:

- Vaccine vials,
- Anaphylaxis kits,
- Alcohol wipes,
- Band-Aids,
- Sharps containers,
- Safety syringes/needles,
- Boxes of gloves,
- Nurse's kit,
- Cash box, and
- Confidentiality folder.

For More Information

For additional strategies that health care professionals can implement that may help increase influenza vaccination rates, visit the following CDC web pages:

- Strategies for Increasing Adult Influenza Vaccination Rates
  http://www.cdc.gov/vaccines/recs/rate-strategies/flustrat.htm
- CDC Guidelines for Large-Scale Influenza Vaccination Clinic Planning
  http://www.cdc.gov/flu/professionals/vaccination/vax_clinic.htm
- CDC Vaccines and Immunizations website for Health Care Professionals
  http://www.cdc.gov/vaccines/hcp.htm

Influenza, Pneumococcal, and Hepatitis B Vaccinations

Resource Materials

Advisory Committee on Immunization Practices Website
http://www.cdc.gov/vaccines/recs/acip/default.htm

American Lung Association
http://www.lungusa.org/site/c.dvLUK9O0E/b.4061173/apps/s/content.asp?ct=2730061

American Lung Association Flu Clinic Locator
http://www.fluclinicslocator.org

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Centers for Disease Control and Prevention Seasonal Flu Website
http://www.cdc.gov/flu

Centers for Disease Control and Prevention Vaccines and Immunization Website
http://cdc.gov/vaccines

CMS Adult Immunization Website
http://www.cms.hhs.gov/AdultImmunizations

Documentation Guidelines for Evaluation and Management Services
http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Immunization Action Coalition
http://www.immunize.org

Indian Health Service
http://www.ihs.gov

Lung Disease At A Glance: Influenza and Pneumonia
http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=316591

Medicare Claims Processing Manual
Select Internet-only manual on the left and then select Pub. 100-04 on the next page.
http://www.cms.hhs.gov/manuals

Beneficiary-related resources can be found in Reference F of this Guide.

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 10
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Enrollment Applications
http://www.cms.hhs.gov/MedicareProviderSupEnroll

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Learning Network Influenza (Flu) Season Educational Products and Resources
http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Matters Article – MM 6079 Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6079.pdf

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Alliance for Hispanic Health
Information on vaccines is available in both English and Spanish.
http://www.hispanichealth.org/factsheets/action.lasso?-response=response1.lasso&RECORD=05060402

National Center for Immunization and Respiratory Disease
http://www.cdc.gov/ncird

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

National Foundation for Infectious Diseases
http://www.nfid.org

National Vaccine Program Office Website
http://www.hhs.gov/nvpo

Partnership for Prevention Website
http://prevent.org

Beneficiary-related resources can be found in Reference F of this Guide.

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Prevention and Control of Influenza
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5707a1.htm?s_cid=rr5707a1_e

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Bone Mass Measurements

Overview

Osteoporosis, or "porous bone," is a disease of the skeletal system characterized by low bone mass and deterioration of bone tissue. Osteoporosis produces an enlargement of the pore spaces in the bone, causing increased fragility and an increased risk for fracture, typically in the wrist, hip, and spine. An estimated 10 million Americans have osteoporosis and over 34 million Americans have low bone mass, placing them at increased risk for osteoporosis. One out of every 2 women and one in 4 men over the age of 50 will have an osteoporosis-related fracture in their lifetime. Osteoporosis is responsible for more than 1.5 million fractures annually[1]–an event that often leads to a decline in physical health and quality of life, including losing the ability to walk, stand up, or dress, and can lead to premature death.

According to the U.S. Surgeon General's 2004 report[2], Bone Health and Osteoporosis: A Report of the Surgeon General, due to the aging of the population and the previous lack of focus on bone health, the number of hip fractures in the U.S. could double or triple by the year 2020. The good news is osteoporosis is a disease that can be prevented and treated. Early diagnosis and treatment can reduce or prevent fractures from occurring. Medicare's bone mass measurement benefit can aid in the early detection of osteoporosis before fractures occur, provide a precursor to future fractures, and determine rate of bone loss.

Bone Mass Measurement Defined

The term "bone mass measurement," also known as "bone density study," is defined as a radiological or radioisotope procedure or other procedure approved by the Food and Drug Administration (FDA) performed on a qualified individual for the purpose of identifying bone mass, detecting bone loss, or determining bone quality. Bone mass measurements are used to evaluate diseases of the bone and/or the responses of the bone disease to treatment; they include a physician's interpretation. The studies assess bone mass or density associated with such diseases as osteoporosis and other bone abnormalities.

Methods of Bone Mass Measurements

Bone density is usually studied by using one of various types of diagnostic bone mass measurement techniques that have been recognized by the FDA. Bone density can be measured at the wrist, spine, hip, or calcaneus (heel). Various single and combined methods of measurement may be required to diagnose bone disease, monitor the course of bone changes with disease progression, or monitor the course of bone changes with therapy.

Medicare provides coverage for the following types of densitometers:

- A **stationary** device that is permanently located in an office
- A **mobile** device that is transported by vehicle from site to site
- A **portable** device that can be picked up and moved from one site to another

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1 National Institutes of Arthritis and Musculoskeletal and Skin Diseases. 2007. Osteoporosis Overview [online]. Bethesda, MD: The National Institutes of Arthritis and Musculoskeletal and Skin Diseases, National Institutes of Health, The U.S. Department of Health and Human Services, December 2007 [cited 21 November 2008]. Available from the World Wide Web: (http://www.niams.nih.gov/Health_Info/Bone/Osteoporosis/default.asp).

2 United States Department of Health and Human Services. 2007. Bone Health and Osteoporosis: A Report of the Surgeon General [online]. Washington, D.C.: The U.S. Department of Health and Human Services, 14 October 2004 [cited 25 November 2008]. Available from the World Wide Web: (http://www.surgeongeneral.gov/library/bonehealth/).

To ensure accurate measurement and consistent test results, bone density studies should generally be performed for periodic follow-up tests on the same suitably precise instrument and results should be obtained from the same scanner when comparing a patient to a control population.

Risk Factors

While anyone can develop osteoporosis, some factors that may put individuals at increased risk for developing the disease include:

- Age 50 or older,
- Female gender,
- Family history of broken bones,
- Personal history of broken bones,
- Caucasian or Asian ethnicity,
- Small-bone structure,
- Low body weight (less than 127 pounds),
- Frequent smoking or drinking, and
- Low-calcium diet.

IMPORTANT NOTE: Although the factors listed above may put individuals at increased risk for developing osteoporosis, Medicare does not provide coverage of bone mass measurement for all beneficiaries in these high risk groups. Medicare provides coverage for bone mass measurements performed on qualified beneficiaries when all of the benefit coverage criteria described below are met.

Coverage Information

The Balanced Budget Act of 1997 (BBA) standardized Medicare coverage of medically necessary bone mass measurements by providing for coverage under Medicare Part B. This coverage took effect on July 1, 1998. Medicare's bone mass measurement benefit includes a physician's interpretation of the results of the procedure.

Medicare pays for bone mass measurements that meet all of the following criteria:

1. Is performed on a qualified individual. A "qualified individual" means a Medicare beneficiary who meets the medical indications for at least one of the five categories listed below:
   - A woman who has been determined by the physician or qualified non-physician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings;
   - An individual with vertebral abnormalities, as demonstrated by an X-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture;
   - An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone, or greater, per day, for more than three months;
   - An individual with known primary hyperparathyroidism; or
   - An individual being monitored to assess the response to, or efficacy of, an FDA-approved osteoporosis drug therapy.

In addition, all of the coverage criteria listed below must be met:

2. The individual's physician or qualified non-physician practitioner treating the beneficiary must provide an order, following an evaluation of the need for a bone mass measurement that includes a determination as to the medically appropriate measurement to be used for the individual.

NOTE: A physician or qualified non-physician practitioner treating the beneficiary for the purpose of the bone mass measurement benefit is one who provides a consultation or treats a beneficiary for a specific medical problem, and who uses the results in the management of the patient. For the purposes of the bone mass measurement benefit, qualified non-physician practitioners include physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives.

3. The service must be a radiologic or radioisotopic procedure (or other procedure) that meets the following requirements:
   - Is performed with a bone densitometer (other than dual photon absorptiometry) or a bone sonometer (i.e., ultrasound) device approved or cleared for marketing by the FDA;
   - Is performed for the purpose of identifying bone mass, detecting bone loss, or determining bone quality; and
   - Includes a physician's interpretation of the results of the procedure.
4. The service must be furnished by a qualified supplier or provider of such services under the appropriate level of supervision by a physician.
5. The service must be reasonable and necessary for diagnosing, treating, or monitoring an individual as defined above.
6. The service must be performed at a frequency that conforms to the requirements described below.

Medicare provides coverage of a bone mass measurement that meets the criteria as described above once every 2 years (i.e., at least 23 months have passed following the month in which the last Medicare-covered bone mass measurement was performed).

NOTE: If medically necessary, Medicare may provide coverage for a beneficiary more frequently than every two years. (See the text box on this page for examples of situations where Medicare may provide more frequent coverage of bone mass measurements.)

Examples of situations where more frequent bone mass measurements may be medically necessary include, but are not limited to, the following medical conditions:

- Monitoring patients on long-term glucocorticoid (steroid) therapy for more than three months.
- Allowing for a confirmatory baseline bone density study to permit monitoring in the future if certain specified requirements are met.

Medicare provides coverage of bone mass measurements as a Medicare Part B benefit. The coinsurance or copayment applies after the yearly Medicare Part B deductible has been met.

Documentation

Medical record documentation maintained by the treating physician must clearly indicate the medical necessity for ordering bone mass measurements. The documentation may be included in any of the following:

- Patient history and physical,
- Office notes,
- Test results with written interpretation, or
- X-ray/radiology with written interpretation.

NOTE: Since not every woman who has been prescribed estrogen replacement therapy (ERT) may be receiving an "adequate" dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating non-physician practitioner from ordering a bone mass measurement for her. If, however, a bone mass measurement is ordered for a woman following a careful evaluation of her medical need, it is expected that the ordering treating physician (or other qualified treating non-physician practitioner) should document in the patient's medical record why he or she believes that the patient is estrogen-deficient and at clinical risk for osteoporosis.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Bone mass measurements are performed to establish the diagnosis of osteoporosis and to assess the individual's risk for subsequent fracture. Bone densitometry includes the use of single energy X-ray absorptiometry (SEXA), dual energy X-ray absorptiometry (DEXA), quantitative computed tomography (QCT), and bone ultrasound densitometry (BUD).

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes listed in Table 1 to report bone mass measurements covered by Medicare:

Table 1 – HCPCS/CPT Codes for Bone Mass Measurements

HCPCS/CPT Code	Code Descriptor
G0130	Single energy x-ray absorptiometry (SEXA) bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)
77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77080	Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

HCPCS/CPT Code	Code Descriptor
77081	Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77083	Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method

NOTE: The following bone mass measurements are noncovered under Medicare because they are not considered reasonable and necessary. [See Section 1862(a)(1)(A) of the Social Security Act]:

- 78350 – Single Photon Absorptiometry, effective January 1, 2007
- 78351 – Dual Photon Absorptiometry, established in 1983

Coding Tip

When billing Medicare for bone mass measurements, a procedure code must be billed only once, regardless of the number of sites being tested or included in the study (e.g., if the spine and hip are performed as part of the same study, only one site can be billed).

NOTE: Monitoring and confirmatory baseline bone mass measurements must be performed with a dual-energy X-ray absorptiometry (axial) test as required by Section 1862 (a)(1)(A) of the Act.

Diagnosis Requirements

Certain bone mass measurement tests are covered when used to screen patients for osteoporosis subject to the frequency standards (see Medicare Benefit Policy Manual, Chapter 15, Section 80.5.5).

Medicare will pay claims for screening tests when coded as follows:

- Contain procedure codes 77078, 77079, 77080, 77081, 77083, 76977, or G0130, and
- Contain a valid ICD-9-CM diagnosis code obtained from the lists of diagnosis codes for the screening benefit's categories that indicate the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.
- Medicare Contractors will maintain a local list of valid codes for the benefit's screening categories.

Medicare will not pay for claims for screening tests when coded as follows:

- Contain procedure codes 77078, 77079, 77081, 77083, 76977, and G0130, but
- Does not contain a valid ICD-9-CM diagnosis code obtained from the local lists of valid ICD-9-CM diagnosis codes maintained by the contractor that indicate the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.

Medicare covers dual-energy X-ray absorptiometry (axial) tests when the tests are used to monitor FDA-approved osteoporosis drug therapy subject to the 2-year frequency standards (see Medicare Benefit Policy Manual, Chapter 15, Section 80.5.5).

Medicare will pay claims for monitoring tests when coded as follows:

- Contains procedure code 77080, and
- Contain 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as the ICD-9-CM diagnosis code.

Medicare will not pay for claims for monitoring tests when coded as follows:

- Contain procedure codes 77078, 77079, 77081, 77083, 76977, or G0130, and
- Contain ICD-9-CM diagnosis codes 733.00, 733.01, 733.02, 733.03, 733.90, or 255.0, but
- Does not contain a valid ICD-9-CM diagnosis code from the local lists of valid ICD-9-CM diagnosis codes maintained by the contractor for the benefit's screening categories indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT codes and the appropriate diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT codes (Table 1), revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for bone mass measurement services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 2:

Table 2 – Facility Types, Types of Bills, and Revenue Codes for Bone Mass Measurements

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B, including CAH	12X	0320
Hospital Outpatient	13X	0320
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0320
SNF Outpatient	23X	0320
Rural Health Clinic (RHC)	71X	052X
Federally Qualified Health Center (FQHC)	73X	052X
CAH*	85X	0320

***NOTE:** Method I – All technical components are paid using standard institutional billing practices.

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X.

NOTE: Effective April 1, 2005, RHCs and FQHCs will no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter, 052X, or 0900. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520.

Reimbursement Information

General Information

The Medicare Part B deductible and coinsurance or copayment apply, except for FQHC services. FQHC services are not subject to a deductible.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare bases reimbursement for bone mass measurements on the Medicare Physician Fee Schedule (MPFS). Non-assigned claims are subject to the Medicare limiting charge.

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Medicare bases reimbursement for bone mass measurements on the current payment methodologies for radiology services, and according to the type of provider.

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of bone mass measurements:

- The appropriate physician or qualified non-physician practitioner did not order the tests (a physician or qualified non-physician practitioner is one who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the patient).
- The beneficiary does not meet the criteria of a qualified individual.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Bone Mass Measurements

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 80.5
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

Medicare Claims Processing Manual – Pub. 100-04, Chapter 13, Section 140
http://www.cms.hhs.gov/manuals/downloads/clm104c13.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Matters Article MM 5521, Bone Mass Measurements (BMMs)
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5521.pdf

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

NIH Osteoporosis and Related Bone Diseases ~ National Resource Center
This is a website provided by the National Institutes of Arthritis and Musculoskeletal and Skin Diseases.
http://www.niams.nih.gov/Health_Info/Bone/default.asp

Beneficiary-related resources can be found in Reference F of this Guide.

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations on screening for osteoporosis.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Notes

Glaucoma Screening

Overview

Glaucoma represents a family of diseases commonly associated with optic nerve damage and visual field changes (a narrowing of the eyes' usual scope of vision). It is the second leading cause of irreversible blindness in the United States.[1] Of the various forms of glaucoma (such as congenital, angle-closure, and secondary), open-angle glaucoma is the most common. It is estimated that over 4 million Americans have glaucoma but only half of those know they have it.[2]

Glaucoma occurs when increased fluid pressure in the eye presses against the optic nerve, causing damage. The damage to optic nerve fibers can cause blind spots to develop. These blind spots usually go undetected until the optic nerve is significantly damaged. If the entire optic nerve is destroyed, blindness results. Since glaucoma progresses with little or no warning signs or symptoms, and vision loss from glaucoma is irreversible, it is very important that people at high risk for the disease receive an annual screening. Studies have shown that the early detection and treatment of glaucoma, before it causes major vision loss, is the best way to control the disease.

Medicare coverage of glaucoma screenings was implemented with the Benefits Improvement and Protection Act of 2000 (BIPA). This coverage took effect on January 1, 2002.

The glaucoma screening covered by Medicare includes:

- A dilated eye examination with an intraocular pressure (IOP) measurement

  AND

- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination

Increased IOP is common with glaucoma. In the past, it was thought that an increased IOP measurement indicated glaucoma; however, an IOP measurement using non-contact tonometry (more commonly known as the "air puff test") alone was commonly used to diagnose glaucoma. Health care professionals now know that glaucoma can be present with or without increased IOP, which makes the examination of the eye and optic nerve (along with the IOP measurement) a critical part of the glaucoma screening.

Risk Factors

While anyone can develop glaucoma, certain groups of people are at higher risk for the disease. Risk factors that may increase an individual's chances of developing glaucoma include age, race, family history, and medical history.

1 The Glaucoma Research Foundation. 2008. Some Statistics About Glaucoma [online]. San Francisco, CA: The Glaucoma Research Foundation, April 2008 [cited 24 November 2008]. Available from the World Wide Web: (http://www.glaucoma.org/learn/glaucoma_facts.php).

2 Ibid

Coverage Information

Medicare provides coverage of an annual glaucoma screening (i.e., at least 11 months have passed following the month in which the last Medicare-covered glaucoma screening examination was performed) for beneficiaries in at least one of the following high risk groups:

- Individuals with diabetes mellitus,
- Individuals with a family history of glaucoma,
- African-Americans age 50 and over, and
- Hispanic-Americans age 65 and over.

Because of the prevalence of glaucoma in these groups, it is of special importance that all eligible Medicare beneficiaries be encouraged to get regular glaucoma screenings.

Medicare will pay for glaucoma screening examinations, in the office setting, when they are furnished by or under the direct supervision of an optometrist or ophthalmologist legally authorized to perform services under State law.

Coverage of the glaucoma screening service is provided as a Medicare Part B benefit. Both deductible and coinsurance apply.

NOTE: Medicare does not provide coverage for routine eye refractions.

Documentation

Medical record documentation must support that the beneficiary is a member of one of the high risk groups previously discussed. The documentation must also support that the appropriate screening (i.e., either a dilated eye examination with an IOP measurement and a direct ophthalmoscopic examination OR a slit-lamp biomicroscopic examination) was performed.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1 to report glaucoma screening services:

Table 1 – HCPCS Codes for Glaucoma Screening Services

HCPCS Code	Code Descriptor
G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist
G0118	Glaucoma screening for high risk patients furnished under the direct supervision of an optometrist or ophthalmologist

Diagnosis Requirements

The beneficiary must be a member of one of the high risk groups mentioned to receive a Medicare-covered glaucoma screening. Medicare providers bill for glaucoma screening using the screening ("V") diagnosis code of V80.1 (Special Screening for Neurological, Eye, and Ear Disease, Glaucoma). For further guidance, contact your Medicare Contractor.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS G code G0117 or G0118 and the corresponding diagnosis V code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, the Medicare provider must report the appropriate HCPCS code G0117 or G0118, the appropriate revenue codes, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for glaucoma screening services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 2:

Table 2 – Facility Types, Types of Bills, and Revenue Codes for Glaucoma Screening Services

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	Hospital outpatient departments are not required to report revenue code 0770; claims must be billed using any valid/appropriate revenue code.
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0770
SNF Outpatient	23X	0770
Rural Health Clinic (RHC)	71X	Use bill type 71X and RHC revenue code 052X to report the related visit. FIs/AB MACs will only pay for the visit, 052X.
Federally Qualified Health Center (FQHC)	73X	Use bill type 73X and FQHC revenue code 052X to report the related visit.
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0770
Critical Access Hospital (CAH)*	85X	0770

***NOTE:** Method I – All technical components are paid using standard institutional billing practices.

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X.

NOTE: Effective April 1, 2005, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter, 052X, or 0900. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520.

Reimbursement Information

General Information

Medicare Part B pays 80 percent of the Medicare-approved amount for the glaucoma screening (deductible and coinsurance or copayment apply).

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare bases reimbursement for glaucoma screening on the Medicare Physician Fee Schedule (MPFS). Claims from physicians or other providers where assignment was not accepted are subject to the Medicare limiting charge. In some situations, glaucoma screening codes are bundled with Evaluation and Management (E/M) codes. Additional information can be found at the National Correct Coding Initiative Edits website at http://www.cms.hhs.gov/NationalCorrectCodInitEd on the CMS website.

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Additional information about OPPS can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for glaucoma screening is dependent upon the type of facility. For providers billing Outpatient Prospective Payment System (OPPS) claims, HCPCS code G0118 is bundled with HCPCS code G0117 if they are both billed on the same day. Additional information can be found at the National Correct Coding Initiative Edits Hospital OPPS website at http://www.cms.hhs.gov/HospitalOutpatientPPS on the CMS website. These codes are not bundled for other providers billing FIs/AB MACs. The following table lists the type of payment that facilities receive for glaucoma screening:

Table 3 – Types of Payments Received by Facilities for Glaucoma Screening Services

If the Facility Is a…	Then Payment is Based On…
Comprehensive Outpatient Rehabilitation Facility (CORF)	Medicare Physician Fee Schedule (MPFS)
Critical Access Hospital (CAH) Method II	101% of reasonable cost plus 115% of the MPFS for the professional component
CAH Method I	101% of reasonable cost
Federally Qualified Health Center (FQHC)	All-inclusive rate for the glaucoma screening based on the visit furnished to the patient
Hospital Inpatient Part B	Outpatient Prospective Payment System (OPPS)
Hospital Outpatient Department	OPPS
Rural Health Clinic (RHC)	All-inclusive rate for the glaucoma screening based on the visit furnished to the patient
Skilled Nursing Facility (SNF) Inpatient Part B	MPFS
SNF Outpatient Services	MPFS

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of glaucoma screening services:

- The beneficiary received covered glaucoma screening services during the past year.
- The beneficiary is not a member of one of the high risk groups.
- Claims submitted without a screening diagnosis code may be returned to the provider as unprocessable.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Glaucoma Screening

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

The Glaucoma Foundation Website
http://www.glaucomafoundation.org

Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 280.1
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 70
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about OPPS.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

The Medline Plus Health Information Website
http://www.nlm.nih.gov/medlineplus

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

Beneficiary-related resources can be found in Reference F of this Guide.

National Eye Institute
Website provides links to Medicare benefits resources that can be ordered by health care professionals for distribution at health fairs, clinics, meal sites, senior centers, and other community locations.
http://www.nei.nih.gov/medicare

Outpatient Prospective Payment System
http://www.cms.hhs.gov/HospitalOutpatientPPS

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Prevent Blindness America Website
http://www.preventblindness.org

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Notes

Smoking and Tobacco-Use Cessation Counseling Services

Overview

Tobacco use continues to be the leading cause of preventable disease and death in the United States. Smoking can attribute to and worsen heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysms, and cataracts. Smoking harms nearly every organ of the body and generally diminishes the health of smokers.

Quitting tobacco use can be difficult. Most smokers are dependent on nicotine, the psychoactive drug in tobacco products that produces dependence. Nicotine dependence is the most common form of chemical dependence in the U.S. Research suggests that nicotine is as addictive as heroin, cocaine, or alcohol. Attempts to quit may be accompanied by symptoms of withdrawal, including irritability, anxiety, difficulty concentrating, and increased appetite. Tobacco dependence is a chronic condition that often requires repeated intervention.

Quitting smoking has immediate as well as long term effects. People who stop smoking greatly reduce their risk of dying prematurely and lower their risk of heart disease, stroke, lung disease, and other health conditions caused by smoking. Benefits are greater for people who stop at earlier ages, but smoking cessation is beneficial at any age.

Older smokers have been shown to be more successful in their attempts to quit than younger smokers and respond favorably to their providers' advice to quit smoking. Brief clinical interventions and counseling by health care providers have been shown to increase the chances of successful cessation.

The Centers for Medicare & Medicaid Services (CMS) determined that the evidence was adequate to conclude that smoking and tobacco-use cessation counseling, based on the current U.S. Public Health Service Guideline, is reasonable and necessary for certain individuals and should be covered by Medicare. On March 22, 2005, Medicare began providing coverage of two levels of counseling for smoking cessation (intermediate and intensive).

Cessation Counseling Attempt Defined

A cessation counseling attempt occurs when a qualified physician or other Medicare-recognized practitioner determines that a beneficiary meets the eligibility requirements and initiates treatment with a cessation counseling attempt. A cessation counseling attempt includes the following:

- Up to four cessation counseling sessions (one attempt = up to four sessions)

Two cessation counseling attempts (or up to 8 cessation counseling sessions) are allowed every 12 months.

Cessation Counseling Session Defined

A cessation counseling session refers to face-to-face patient contact at one of two levels:

- Intermediate (greater than 3 minutes up to 10 minutes), or
- Intensive (greater than 10 minutes).

Cessation counseling sessions may be performed "incident to" the services of a qualified practitioner.

Coverage Information

Medicare provides coverage of smoking and tobacco-use cessation counseling services for beneficiaries who meet one of the following criteria:

- Use tobacco and have a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use, or
- Are taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on Food and Drug Administration-approved information.

Medicare will cover two cessation attempts per year. Each attempt may include a maximum of four counseling sessions. The total annual benefit covers up to 8 smoking and tobacco-use cessation counseling sessions in a 12-month period. The beneficiary may receive another 8 counseling sessions during a second or subsequent year after 11 full months have passed since the first Medicare-covered cessation counseling session was performed. For example, if the first of eight covered sessions was performed in December 2009, a second series of eight sessions may begin in December 2010.

Beneficiaries must be competent and alert at the time services are provided.

Intermediate and intensive smoking cessation counseling services will be covered for outpatient and hospitalized beneficiaries who are smokers and meet all coverage requirements, as long as the services are furnished by qualified physicians or other Medicare-recognized practitioners.

During a 12-month period, the practitioner and the beneficiary have the flexibility to choose between intermediate or intensive counseling strategies for each session.

Eligible beneficiaries are covered under Medicare Part B. Both coinsurance and deductible apply.

Reminder

Medicare's prescription drug benefit also covers smoking and tobacco-use cessation agents prescribed by a physician.

NOTE: Medicare covers minimal cessation counseling (defined as three minutes or less in duration) as part of eachEvaluation and Management (E/M) visit and is not separately billable.

Documentation

Keep patient record information on file for each Medicare beneficiary for whom a smoking and tobacco-use cessation counseling claim is made. Medical record documentation must include standard information along with sufficient beneficiary history to adequately demonstrate that Medicare coverage conditions were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Current Procedural Terminology (CPT) codes listed in Table 1 to report smoking and tobacco-use cessation counseling services:

Table 1 – CPT Codes for Smoking and Tobacco Use Cessation Counseling Services

CPT Code	Code Descriptor
99406	Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

NOTE: Payment may be allowed for a medically necessary E/M service on the same day as the smoking and tobacco-use cessation counseling service when it is clinically appropriate. Physicians and qualified non-physician practitioners shall use the appropriate CPT code, such as 99201 through 99215, to report an E/M service with modifier -25 to indicate that the E/M service is a separately identifiable service from a smoking and tobacco-use cessation counseling service.

Diagnosis Requirements

Medicare providers must submit claims for smoking and tobacco-use cessation counseling services with an appropriate diagnosis code. Diagnosis codes should reflect the following:

- The condition the patient has that is adversely affected by tobacco use, or
- The condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

For further guidance, contact your Medicare Contractor.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians or qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate CPT code 99406 or 99407 and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

Carriers/AB MACs will pay for smoking and tobacco-use cessation counseling services billed with CPT codes 99406 and 99407 for dates of service on or after January 1, 2008. Carriers/AB MACs will pay for counseling services billed with Healthcare Common Procedure Coding System (HCPCS) codes G0375 and G0376 for dates of service performed on or after March 22, 2005 through December 31, 2007.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, the Medicare provider must report the appropriate CPT code 99406 or 99407, the appropriate revenue codes, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

FIs/AB MACs will pay for smoking and tobacco-use cessation counseling services with CPT codes 99406 and 99407 for dates of service on or after January 1, 2008. FIs/AB MACs will pay for counseling services billed with codes HCPCS codes G0375 and G0376 for dates of service performed on or after March 22, 2005 through December 31, 2007.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for smoking and tobacco-use cessation counseling services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 2:

Table 2 – Facility Types, Types of Bills, and Revenue Codes for Smoking and Tobacco-Use Cessation Counseling Services

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B	12X	0942
Hospital Outpatient	13X	0942
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0942
SNF Outpatient	23X	0942

Facility Type	Type of Bill	Revenue Code
Home Health Agency (HHA)	34X	0942
Rural Health Clinic (RHC)	71X	052X
Federally Qualified Health Center (FQHC)	73X	052X
Hospital Outpatient Surgery	83X	0942
Critical Access Hospital (CAH) Methods I and II, Technical Component (TC) only	85X	0942
CAH Method II, Professional Component (PC) only	85X	096X, 097X, or 098X
Indian Health Service (IHS) CAH	85X	0510
IHS	12X, 13X	0510

NOTE: When these services are provided by a Clinical Nurse Specialist in the RHC/FQHC setting, they are considered "incident to" and do not constitute a billable visit.

NOTE: Based on Section 1861(cc) of the Social Security Act, smoking cessation is not listed as a Comprehensive Outpatient Rehabilitation Facility (CORF) benefit and cannot be billed or paid as a CORF service. Effective July 1, 2008, Outpatient Physical Therapy (OPT) provider TOB 74X and CORF TOB 75X are no longer applicable bill types for smoking and tobacco-use cessation counseling services.

Reimbursement Information

General Information

The Medicare Part B deductible and coinsurance or copayment will apply.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare reimbursement for smoking and tobacco-use cessation counseling services is based on the Medicare Physician Fee Schedule (MPFS).

Unassigned claims are subject to the Medicare limiting charge.

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for smoking and tobacco-use cessation counseling services is dependent upon the type of facility. The following table lists the type of payment that facilities receive for smoking and tobacco-use cessation counseling services:

Table 3 – Types of Payments Received by Facilities for Smoking and Tobacco-Use Cessation Counseling Services

If the Facility is a…	Then Payment is Based On…
Critical Access Hospital (CAH)	Method I: Technical services are paid at 101% of reasonable cost Method II: Technical services are paid at 101% of reasonable cost Professional services are paid at 115% of Medicare Physician Fee Schedule (MPFS)
Federally Qualified Health Center (FQHC)	All-inclusive rate for the encounter
Home Health Agency (HHA)	MPFS
Hospital Outpatient	Ambulatory Payment Classification (APC) for hospitals subject to the Outpatient Prospective Payment System (OPPS). Hospitals not subject to OPPS are paid under current methodologies.
Indian Health Service (IHS)/Tribally owned or operated hospital and hospital-based facility	All-inclusive rate for the encounter
IHS/Tribally owned or operated non-hospital-based facility	MPFS
IHS/Tribally owned or operated Critical Access Hospital (CAH)	Facility Specific Visit Rate
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	94% of submitted charges, subject to any unmet deductible, coinsurance, and non-covered charges policies
Rural Health Clinic (RHC)	All-inclusive rate for the encounter
Skilled Nursing Facility (SNF) NOTE: Included in Part A Prospective Payment System (PPS) for skilled patients	MPFS

NOTE: Inpatient claims submitted with smoking and tobacco-use cessation counseling services are processed under the current payment methodologies.

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of smoking and tobacco-use cessation counseling sessions:

- The beneficiary dates of service exceed a combined total of 8 sessions in a 12-month period.
- The beneficiary did not meet the eligibility requirements for this service.
- The beneficiary has reached the maximum therapeutic benefit.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Smoking and Tobacco-Use Cessation Counseling Services

Resource Materials

Agency for Healthcare Research and Quality
http://www.ahrq.gov/path/tobacco.htm

American Cancer Society
http://www.cancer.org/docroot/home/index.asp

American Lung Association
http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=22542

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Centers for Disease Control and Prevention Tobacco Information and Prevention Source (TIPS)
http://www.cdc.gov/tobacco

Department of Health and Human Services Smokefree.gov
http://smokefree.gov/hp.html

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Medicare Claims Processing Manual – Pub. 100-04, Chapter 32, Section 12
http://www.cms.hhs.gov/manuals/downloads/clm104c32.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about OPPS.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Beneficiary-related resources can be found in Reference F of this Guide.

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

National Institutes of Health Tobacco Control Research
http://dccps.nci.nih.gov/tcrb

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

Smoking Cessation Overview
http://www.cms.hhs.gov/SmokingCessation

Tobacco Cessation Guidelines
http://www.surgeongeneral.gov/tobacco/index.html

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

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http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.

Notes

Reference A: Acronyms

Acronym	Description
AAA	Abdominal Aortic Aneurysm
AAO	American Academy of Ophthalmology
AADE	American Association of Diabetes Education
ABN	Advance Beneficiary Notice of Noncoverage
ACIP	Advisory Committee on Immunization Practices
ACS	American Cancer Society
ADA	American Diabetes Association
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
AIR	All-Inclusive Rate
AMA	American Medical Association
ANSI	American National Standards Institute
APC	Ambulatory Payment Classification
ARNP	Advanced Registered Nurse Practitioner
ASC	Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ATS	American Thoracic Society
AWP	Average Wholesale Price
BBA	Balanced Budget Act of 1997
BIPA	Benefits Improvement and Protection Act of 2000
BMM	Bone Mass Measurement
BNI	Beneficiary Notices Initiative

Acronym	Description
BUD	Bone Ultrasound Densitometry
CAD	Computer-Aided Detection
CAH	Critical Access Hospital
CARC	Claim Adjustment Reason Code
CBA	Competitive Bidding Area
CCI	Correct Coding Initiative
CDC	Centers for Disease Control and Prevention
CLFS	Clinical Laboratory Fee Schedule
CMS	Centers for Medicare & Medicaid Services
CNS	Clinical Nurse Specialist
CO	Central Office (CMS Central Office)
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CSII	Continuous Subcutaneous Insulin Infusion
CWF	Common Working File
DES	Diethylstilbestrol
DEXA	Dual Energy X-ray Absorptiometry
DFARS	Defense Federal Acquisition Regulation System
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DNA	Deoxyribonucleic Acid
DRA	Deficit Reduction Act of 2005

Acronym	Description
DRE	Digital Rectal Examination
DRG	Diagnosis-Related Group
DSMO	Designated Standard Maintenance Organization
DSMT	Diabetes Self-Management Training
ECG	Electrocardiogram
EDI	Electronic Data Interchange
EKG	Electrocardiogram
E/M	Evaluation and Management
EMC	Electronic Media Claims
ERT	Estrogen Replacement Therapy
ESRD	End-Stage Renal Disease
FARS	Federal Acquisition Regulation System
FDA	Food and Drug Administration
FI	Fiscal Intermediary
FFS	Fee-For-Service
FOBT	Fecal Occult Blood Test
FQHC	Federally Qualified Health Center
GFR	Glomerular Filtration Rate
GTT	Glucose Tolerance Test
HBV	Hepatitis B Virus
HCPCS	Healthcare Common Procedure Coding System
HDL	High Density Lipoprotein
HHA	Home Health Agency
HICN	Health Insurance Claim Number

Acronym	Description
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HSCRC	Health Services Cost Review Commission
IAC	The Immunization Action Coalition
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
IDSA	Infectious Diseases Society of America
IHS	Indian Health Service
IOP	Intraocular Pressure
IPPE	Initial Preventive Physical Examination
LCSW	Licensed Clinical Social Worker
LDL	Low Density Lipoprotein
MAC	Medicare Administrative Contractor
MedQIC	Medicare Quality Improvement Community
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MLN	Medicare Learning Network
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MNT	Medical Nutrition Therapy
MPFS	Medicare Physician Fee Schedule
MQSA	Mammography Quality Standards Act of 1992
MSA	Metropolitan Statistical Area
MSN	Medicare Summary Notice
NCD	National Coverage Determination
NCHS	National Centers for Health Statistics

Acronym	Description
NCI	National Cancer Institute
NDIC	National Diabetes Information Clearinghouse
NEI	National Eye Institute
NEMB	Notice of Exclusion for Medicare Benefits
NFID	The National Foundation for Infectious Diseases
NHLBI	National Heart, Lung, and Blood Institute
NIH	National Institutes of Health
NNII	National Network for Immunization Information
NPI	National Provider Identifier
NUBC	National Uniform Billing Committee
OBRA 1989	Omnibus Budget Reconciliation Act of 1989
OBRA 1990	Omnibus Budget Reconciliation Act of 1990
OMB	Office of Management and Budget
OPPS	Outpatient Prospective Payment System
OPT	Outpatient Physical Therapy
PA	Physician Assistant
PC	Professional Component
POS	Place of Service
PPS	Prospective Payment System
PPV	Pneumococcal Polysaccharide Vaccine
PSA	Prostate Specific Antigen
QCT	Quantitative Computed Tomography
RA	Remittance Advice
RARC	Remittance Advice Remark Code

Acronym	Description
RDF	Renal Dialysis Facility
RHC	Rural Health Clinic
SCHIP	State Children's Health Insurance Program
SEXA	Single Energy X-ray Absorptiometry
SHIP	State Health Insurance Assistance Program
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility
SNIP	Strategic National Implementation Process
STD	Sexually Transmitted Disease
TC	Technical Component
TIPS	Tobacco Information and Prevention Source
TOB	Type of Bill
UPIN	Unique Provider Identification Number
URAC	Utilization Review Accreditation Commission
USPSTF	United States Preventive Services Task Force
WHO	World Health Organization
WMV	Welcome to Medicare Visit
WPC	Washington Publishing Company

Notes

Notes

Reference B: Glossary

A

Abdominal Aortic Aneurysm (AAA) - An aneurysm that occurs in the aorta in the abdomen is called an abdominal aortic aneurysm. Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time only preventive ultrasound screening for the early detection of AAAs for at-risk beneficiaries, resulting from a referral from an Initial Preventive Physical Examination (IPPE).

Accredited (Accreditation) - Having a seal of approval. Being accredited means that a facility or health care organization has met certain quality standards. These standards are set by private, nationally recognized groups that check on the quality of care at health care facilities and organizations. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (URAC).

Act/Law/Statute - The term for legislation that passed through Congress and was signed by the President or passed over the President's veto.

Actual Charge - The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves.

Administrative Simplification Compliance Act (ASCA) - Signed into law on December 27, 2001 as Public Law 107-105, this Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Consequently, unless a provider fits one of the exceptions, any paper claims that are submitted to Medicare will not be paid.

Advance Beneficiary Notice of Noncoverage (ABN) - Generally, an Advance Beneficiary Notice of Noncoverage (ABN) is a written notice a provider, practitioner, physician, or supplier gives to a Medicare beneficiary before items or services are furnished when they believe that Medicare probably or certainly will not pay for some or all of the items or services on the basis that the items or services are "not reasonable and necessary" [Section 1862(a)(1)]; are "custodial care" [Section 1862(a)(9)]; or are denied coverage because the beneficiary is not "homebound", does not need intermitted skilled nursing services, or is not terminally ill [Section 1879(g)].

ABNs are designed for use with Medicare beneficiaries only and allow beneficiaries to have a greater role in their own health care treatment decisions. ABNs provide beneficiaries with the opportunity to make informed consumer decisions as to whether they want to receive items and/or services for which they may be personally and fully responsible, either out of their own pocket, or through other insurance they may have. The failure to properly deliver an ABN in situations where one is required may result in the provider, practitioner, physician, or supplier being held financially liable, unless they can show that they did not know and could not reasonably have been expected to know that Medicare would deny payment. To be acceptable, an ABN must be on the approved Form CMS-R-131; must clearly identify the particular item or service for which the notice is being provided; and must clearly state the reason that the provider, practitioner, physician, or supplier believes Medicare probably or certainly will not pay for the item or service.

Advisory Committee on Immunization Practices (ACIP) - Committee that develops written recommendations for the routine administration of vaccines to pediatric and adult populations, along with schedules regarding the appropriate periodicity, dosage, and contraindications applicable to the vaccines. ACIP is the only entity in the Federal Government that makes such recommendations.

Allowed Amount - Individual charge determined by a carrier/AB Medicare Administrative Contractor (AB MAC) for a covered Supplementary Medical Insurance (SMI) medical service or supply.

Ambulatory Surgical Center (ASC) - A freestanding facility, other than a hospital or physician's office, where outpatient surgical and diagnostic services are provided. At an ambulatory (in and out) surgery center, the beneficiary may stay for only a few hours or for one night.

ANSI X12N 835 - The Health Insurance Portability and Accountability Act of 1996 (HIPAA)-mandated electronic transaction format for Health Care Claim Payment/Advice submissions.

ANSI X12N 837 - The Health Insurance Portability and Accountability Act of 1996 (HIPAA)-mandated electronic transaction format for Health Care Claims.

Approved Amount/Charge - The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by the beneficiary and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Assessment - The gathering of information to rate or evaluate a beneficiary's health and needs, such as in a nursing home.

Assignment - Agreement by a physician, provider, or supplier to accept the Medicare Fee Schedule amount as payment in full for the rendered service. The physician or supplier must submit the claim for the patient, and the payment is remitted directly to the physician or supplier.

Attending Physician - A doctor of medicine or osteopathy, who is fully knowledgeable about the beneficiary's medical condition, and who is responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

B

Barium Enema - A procedure in which the beneficiary is given an enema with barium. X-rays are taken of the colon that allow the physician to see the outline of the beneficiary's colon to check for polyps or other abnormalities.

Beneficiary - An individual who is entitled to Medicare Part A and/or Medicare Part B.

Billing Providers - The provider who submits a claim for payment on services he/she has performed or, in some cases, the group, such as a clinic, bills for the performing providers within the group.

Bone Density Studies (Bone Mass Measurements) - Tests used to measure bone density in the spine, hip, calcaneus, and/or wrist, the most common sites of fractures due to osteoporosis.

Bone Ultrasound Densitometry - The established standard for measuring bone mineral density, most commonly measured in the heel or the tibia.

Bundled - Refers to a group of services listed under one code.

C

Cardiovascular Screening Blood Test - A preventive service provided by Medicare that tests triglyceride, high-density lipoprotein, and total cholesterol levels to identify possible risk factors for cardiovascular disease.

Carrier - A contractor for the Centers for Medicare & Medicaid Services (CMS) that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments.

Centers for Medicare & Medicaid Services (CMS) - The Department of Health and Human Services (DHHS) agency responsible for Medicare and parts of Medicaid. The Centers for Medicare & Medicaid Services has historically maintained the institutional Electronic Media Claims (EMC) format specifications and specifications for various certifications and authorizations used by the Medicare and Medicaid Programs. CMS is responsible for oversight of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the Healthcare Common Procedure Coding System (HCPCS) medical code set and the Remittance Advice Remark Codes (RARCs) administrative code set. CMS is the division of DHHS that administers Medicare and works with State departments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

Centralized Billing - An optional program for providers who qualify to enroll with Medicare as the provider type "mass immunizer." Additional criteria must also be met.

Certified - A hospital that has passed a survey done by a State Government agency. Being certified is not the same as being accredited. Medicare only covers care in hospitals that are certified or accredited.

Claim Adjustment Reason Codes (CARCs) - A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is used in the American National Standards Institute (ANSI) X12N 835 Claim Payment & Remittance Advice and the ANSI X12N 837 Claim transactions, and is maintained by the Health Care Code Maintenance Committee.

Coinsurance (Medicare Private Fee-For-Service Plan) - The percentage of the Private Fee-For-Service Plan charge for services that beneficiaries may have to pay after they pay any plan deductibles. In a Private Fee-For-Service Plan, the coinsurance payment is a percentage of the cost of the service (e.g., 20 percent) - the percent of the Medicare-approved amount that beneficiaries pay after satisfying the deductible for Part A and/or Part B.

Coinsurance [Outpatient Prospective Payment System (OPPS)] - The percentage of the Medicare payment rate or a hospital's billed charge that beneficiaries have to pay after they pay the deductible for Medicare Part B services.

Colonoscopy - A procedure used to check for polyps or cancer in the rectum and the entire colon.

Comprehensive Outpatient Rehabilitation Facility (CORF) - A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.

Computer-Aided Detection (CAD) - The use of a laser beam to scan the mammography film from a film (analog) mammography, to convert it into digital data for the computer, and to analyze the video display for areas suspicious for cancer.

Contractor - An entity that has an agreement with the Centers for Medicare & Medicaid Services (CMS) or another funding agency to perform a project.

Copayment - In some Medicare health plans, the amount that is paid by the beneficiary for each medical service, like a doctor's visit. A copayment is usually a set amount paid for a service. For example, this could be $10 or $20 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Covered Benefit - A health service or item that is included in a health plan and that is paid for either partially or fully.

Critical Access Hospital (CAH) - A small facility that gives limited outpatient and inpatient hospital services to individuals in rural areas.

Current Procedural Terminology (CPT) - A medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of the Department of Health and Human Services (DHHS) as the standard for reporting physician and other services on standard transactions.

D

Deductible - The amount a beneficiary must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

Deficit Reduction Act of 2005 (DRA) – The Deficit Reduction Act of 2005 (DRA), signed into law on February 8, 2006, was enacted to reduce outlays from direct Government spending. A number of the law's provisions were effective on January 1, 2006.

Department of Health and Human Services (DHHS) - The United States Government's principal agency for providing essential human services. DHHS includes more than 300 programs, including Medicare, Medicaid, and the Centers for Disease Control and Prevention (CDC). DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. [It is the "parent" of the Centers for Medicare & Medicaid Services (CMS).]

DES (diethylstilbestrol) - A drug given to pregnant women from the early 1940s until 1971 to help with common problems during pregnancy. The drug has been linked to cancer of the cervix or vagina in women whose mothers took the drug while pregnant. A synthetic compound used as a potent estrogen but contraindicated in pregnancy for its tendency to cause cancer or birth defects in offspring.

Diabetes Self-Management Training (DSMT) Services - A program intended to educate beneficiaries in the successful self-management of diabetes. The program includes:

- Instructions in self-monitoring of blood glucose
- Education about diet and exercise
- An insulin treatment plan developed specifically for insulin dependent beneficiaries
- Motivation for beneficiaries to use the skills for self-management

Diagnosis Code - The first of these codes is the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization). The remaining codes are the ICD-9-CM diagnosis codes corresponding to additional conditions that coexisted at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.

Diagnosis-Related Group (DRG) - A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Diagnostic Mammography - Mammography used to diagnose unusual breast changes, such as a lump, pain, thickening, nipple discharge, or a change in breast size or shape. A diagnostic mammogram is also used to evaluate changes detected on a screening mammogram.

Dialysis Facility (Renal) - A unit (hospital-based or freestanding) that is approved to furnish dialysis services directly to End-Stage Renal Disease (ESRD) patients.

Dietician/Nutritionist - A specialist in the study of nutrition.

Digital Rectal Exam (DRE) - A clinical examination of the prostate for abnormalities such as swelling and nodules of the prostate gland.

Dilated Eye Exam - An examination of the eye involving the use of medication to enlarge the pupils, which allows more of the eye to be seen.

Direct Ophthalmoscopic Examination - An examination of the eye using an ophthalmoscope, an instrument for viewing the interior of the eye.

Dual Energy X-ray Absorptiometry (DEXA) - X-ray densitometry that measures the bone mass in the spine, hip, or total body.

Durable Medical Equipment (DME) - Medical equipment that is ordered by a doctor (or, if Medicare allows, a nurse practitioner, physician assistant, or clinical nurse specialist) for use in the home. A hospital or nursing home that mostly provides skilled care cannot qualify as a "home" in this situation. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

Durable Medical Equipment Medicare Administrative Contractor (DME MAC) - A contractor for the Centers for Medicare & Medicaid Services (CMS) that provides Medicare claims processing and payment of Durable Medical Equipment (DME), prosthetics, orthotics, and supplies for a designated region of the country.

Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) - Purchased or rented items that are covered by Medicare, such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a beneficiary's home.

Durometer - A measure of surface resistivity or material hardness.

E

Electrocardiogram (EKG) - A graphical recording of the cardiac cycle produced by an electrocardiograph, an instrument used in the detection and diagnosis of heart abnormalities.

End-Stage Renal Disease (ESRD) - Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Evaluation and Management (E/M) - A review of a beneficiary's systems and/or past, family, or social history.

F

Fasting Blood Glucose Test - A measurement of blood glucose level taken after the beneficiary has not eaten for 8 to 12 hours (usually overnight). This test is used to diagnose pre-diabetes and diabetes. It is also used to monitor individuals with diabetes.

Fecal Occult Blood Test (FOBT) - A test that checks for occult or hidden blood in the stool.

Federally Qualified Health Center (FQHC) - A health center that has been approved by the Federal Government for a program to serve underserved areas and populations. Medicare pays for a full range of practitioner services (physician and qualified non-physician) in FQHCs as well as certain preventive health services that are not usually covered under Medicare. FQHCs include community health centers, migrant health services, health centers for the homeless, and tribal health clinics.

Fee Schedule - A complete listing of fees used by health plans to pay doctors or other providers.

Fiscal Intermediary (FI) - A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

Flexible Sigmoidoscopy - A procedure used to check for polyps or cancer in the rectum and the lower third of the colon.

Food and Drug Administration (FDA) - Federal agency that is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, food supply, cosmetics, and products that emit radiation.

Form CMS-855 - The form used to enroll in Medicare.

Form CMS-1450 - The form used to bill the Fiscal Intermediary (FI)/AB Medicare Administrative Contractor (AB MAC) for services provided to a Medicare beneficiary.

Form CMS-1500 - The form used to bill the carrier/AB Medicare Administrative Contractor (AB MAC) for services provided to a Medicare beneficiary.

G

Global Component - When referencing billing/payment requirements, the combination of both the technical and professional components.

Government Entities - Entities, such as public health clinics, that may bill Medicare for influenza, pneumococcal, and hepatitis B vaccines administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

H

Health Care Provider - A person who is trained and licensed to give health care. Also, a place that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

Healthcare Common Procedure Coding System (HCPCS) - A uniform method for providers and suppliers to report professional services, procedures, and supplies. HCPCS includes Current Procedure Technology (CPT) codes (Level I), national alphanumeric codes (Level II), and local codes (Level III) assigned and maintained by local Medicare Contractors.

Health Insurance Claim Number (HICN) - A unique 10 or 11-digit alphanumeric Medicare entitlement number assigned to a Medicare beneficiary; appears on the Medicare Health Insurance card.

Health Insurance Portability and Accountability Act (HIPAA) - A law passed in 1996 that is also sometimes called the "Kassebaum-Kennedy" law. The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing various unrelated provisions of HIPAA, therefore HIPAA may mean different things to different people. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. The Administrative Simplification provisions of HIPAA Title II require the Department of Health and Human Services (DHHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers.

Hepatitis B Vaccine - A vaccine administered to prevent Hepatitis B Virus (HBV) infection.

Hepatitis B Virus (HBV) - A serious disease caused by a virus that attacks the liver. It can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

Home Health Agency (HHA) - An organization that gives home care services, such as skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Home Health Care - Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, Durable Medical Equipment (DME) (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice - A facility providing pain relief, symptom management, and supportive services to terminally ill people and their families; an eligible beneficiary must have a life expectancy of six months or less. Hospice care is covered under Medicare Part A (Hospital Insurance).

Hospital Insurance (Part A) - The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

I

Immunoassay - A test that uses the binding of antibodies to antigens to identify and measure certain substances. Immunoassays may be used to diagnose disease and can aid in planning treatment.

Immunosuppressive Drugs - Drugs used to reduce the risk of rejecting new organs after transplant. Transplant patients will need to take these drugs for the rest of their lives.

Indian Health Service (IHS) - An agency within the Department of Health and Human Services (DHHS) responsible for providing Federal health services to American Indians and Alaskan Natives.

Influenza - Also known as the flu virus, is a contagious disease that is caused by the influenza virus. It attacks the respiratory tract in humans (nose, throat, and lungs). Influenza is a serious illness that can lead to pneumonia.

Influenza Vaccine - A vaccine administered to prevent influenza virus infection.

Infusion Pumps - Pumps used for giving fluid or medication intravenously at a specific rate or over a set amount of time.

Initial Preventive Physical Examination (IPPE) - Section 611 of the MMA expanded preventive services to include coverage, under Medicare Part B, of a one-time initial preventive physical examination (IPPE), also referred to as the "Welcome to Medicare Physical Exam" or the "Welcome to Medicare Visit" (WMV). Medicare beneficiaries whose Medicare Part B effective date began on or after January 1, 2005 are covered for a one-time IPPE visit. Effective January 1, 2009, the IPPE must be received within 12 months of their Medicare Part B effective date. The goals of the IPPE are health promotion and disease detection, and include education, counseling, end-of-life planning, and referral to screening and preventive services also covered under Medicare Part B.

International Classification of Diseases (ICD) - A medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set was to classify causes of death. A United States extension, maintained by the National Centers for Health Statistics (NCHS) within the Centers for Disease Control and Prevention (CDC), identifies morbidity factors or diagnoses. The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes have been selected for use in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions.

Intraocular Pressure Measurement (IOP Measurement) - A measurement of the intraocular pressure in the eye; used as a part of a preventive glaucoma screening.

L

Limiting Charge - In the Original Medicare Plan, the highest amount of money that can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

M

Mammography Quality Standards Act of 1992 (MQSA) - Informs mammography facility personnel, inspectors, and other interested individuals about mammography quality standards.

Mass Immunization Center - A location where providers administer pneumococcal and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or use the roster billing method. This generally takes place in a mass immunization setting such as a public health center, pharmacy, or mall, but may include a physician's office setting.

Mass Immunizer - A provider who chooses to enroll in Medicare with this identifier, which demands that the provider meet certain criteria and follow certain procedures when immunizing Medicare beneficiaries.

Medically Necessary - Services or supplies that:

- Are proper and needed for the diagnosis or treatment of a medical condition
- Are provided for the diagnosis, direct care, and treatment of a medical condition
- Meet the standards of good medical practice in the medical community of the local area
- Are not mainly for the convenience of the patient or doctor

Medical Nutrition Therapy (MNT) - Nutritional therapy covered by Medicare for beneficiaries diagnosed with diabetes or a renal disease. For the purpose of disease management, covered MNT services include:

- An initial nutrition and lifestyle assessment
- Nutrition counseling
- Information regarding diet management
- Follow-up sessions to monitor progress

MNT services must be provided by a registered dietitian, or nutrition professional who meets the provider qualification requirements, or a "grandfathered" dietitian or nutritionist who was licensed as of December 21, 2000.

Medicare Administrative Contractor (MAC) - The contracting organization that is responsible for the receipt, processing, and payment of Medicare claims. In addition to providing core claims processing operations for both Medicare Part A and Part B, they will perform functions related to: Beneficiary and Provider Service, Appeals, Provider Outreach and Education (also referred to as Provider Education and Training), Financial Management, Program Evaluation, Reimbursement, Payment Safeguards, and Information Systems Security.

Medicare Clinical Laboratory Fee Schedule (CLFS) - A complete listing of fees that Medicare uses to pay clinical laboratories.

Medicare Contractor - A Medicare Part A Fiscal Intermediary (FI) (institutional), Medicare Part B Carrier (professional), Medicare Administrative Contractor (AB MAC), or Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

Medicare Coverage - Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). [See: Medicare Part A (Hospital Insurance); Medicare Part B (Medical Insurance).]

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) - Legislation enacted on July 15, 2008 that altered a number of Medicare policies including: new 2008 Medicare Physician Fee Schedule (MPFS) payment rates; extension of the exceptions process for the therapy caps; and a delay in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

Medicare Part A - Hospital insurance that pays for inpatient hospital stays, care in a Skilled Nursing Facility (SNF), hospice care, and some home health care.

Medicare Part B - Medical insurance that helps pay for doctors' services, outpatient hospital care, Durable Medical Equipment (DME), and some medical services that are not covered by Part A.

Medicare Physician Fee Schedule (MPFS) - A complete list of medical procedure codes and the maximum dollar amounts Medicare will allow for each service rendered for a beneficiary.

Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 - A comprehensive bill, signed by President George W. Bush on December 8, 2003, that expanded many different phases of Medicare and introduced the Medicare prescription drug coverage. The MMA also expanded the list of preventive services covered by Medicare.

N

National Provider Identifier (NPI) - A 10-digit provider identification number that replaced all legacy transaction numbers [e.g., Unique Provider Identification Numbers (UPINs), Blue Cross and Blue Shield numbers, CHAMPUS numbers, and Medicaid numbers] in all standardized Medicare transactions.

Non-Assigned Claim - A type of claim that directs payment to the beneficiary and may only be filed by a non-participating Medicare physician; when a claim is filed non-assigned the beneficiary is reimbursed directly.

Non-Government Entities - Entities that do not charge patients who are unable to pay, or reduce charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided. These entities may bill Medicare and expect payment.

Non-Participating Physician/Supplier - A physician practice/supplier that has not elected to become a Medicare participating physician/supplier [i.e., one that has retained the right to accept assignment on a case-by-case basis (compared to a participating physician)].

Non-Physician Practitioner - A health care provider who meets State licensing requirements to provide specific medical services. Medicare allows payment for services furnished by qualified non-physician practitioners, including, but not limited to: advanced registered nurse practitioners (ARNPs), clinical nurse specialists (CNSs), licensed clinical social workers (LCSWs), physician assistants (PAs), nurse midwives, physical therapists, and audiologists.

Nurse Practitioner - A nurse who has two or more years of advanced training and has passed a special examination. A nurse practitioner often works with a doctor and can do some of the same things a doctor does.

O

Original Medicare Plan - A pay-per-visit health plan that lets beneficiaries go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. Beneficiaries must pay the deductible. Medicare pays its share of the Medicare-approved amount, and beneficiaries pay their share (coinsurance). In some cases, they may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Orthotists - An individual who provides a range of splints, braces, and special footwear to aid movement, correct deformity, and relieve discomfort.

Outpatient Hospital Services - Medical or surgical care that Medicare Part B helps pay for that does not include an overnight hospital stay. These services include:

- Blood transfusions
- Certain drugs
- Hospital billed laboratory tests
- Mental health care
- Medical supplies such as splints and casts
- Emergency room or outpatient clinic, including same day surgery
- X-rays and other radiation services

P

Pap Test - A test used to check for cancer of the cervix, the opening to a woman's womb. The test is performed by removing cells from the cervix and preparing the cells so they can be seen under a microscope.

Participating Physician/Supplier - A physician practice/supplier that has elected to provide all Medicare Part B services on an assigned basis for a specified period of time.

Pedorthist - An individual who is trained in the assessment, design, manufacture, fit, and modification of foot appliances and footwear for the purposes of alleviating painful or debilitating conditions and providing assistance for abnormalities or limited actions of the lower limb.

Pelvic Exam - An examination to check if internal female organs are normal by feeling the shape and size of the organs.

Photodensitometry - A method of using an X-ray source, radiographic film, and a known standard with which to compare the bones being analyzed. This technique is also called radiodensitometry.

Physical Therapy - Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage.

Plan of Care - A plan by a diabetic beneficiary's managing physician required for coverage of Diabetes Self-Management Training (DSMT) services by Medicare. This plan of care must describe the content, number of sessions, frequency, and duration of the training written by the physician (or qualified non-physician practitioner). The plan of care must also include a statement by the physician (or qualified non-physician practitioner) and the signature of the physician (or qualified non-physician practitioner) denoting any changes to the plan of care.

Pneumococcal Diseases (pneumonia) - Infections caused by the bacteria Streptococcus pneumoniae, also known as pneumococcus. The most common types of infections caused by this bacterium include middle ear infections, pneumonia, blood stream infections (bacteremia), sinus infections, and meningitis.

Pneumococcal Polysaccharide Vaccine - A vaccine administered to prevent pneumococcal diseases.

Post Glucose Challenge - A measurement of blood glucose taken one hour after the ingestion of a liquid containing glucose.

Preventive Services - Health care services provided to beneficiaries to maintain health or to prevent illness. Examples include Pap screening tests, pelvic exams, mammograms, and influenza virus vaccinations.

Primary Care Physician - A physician who is trained to provide basic care. This includes being the first to check on health problems and coordinating preventive health care with other doctors, specialists, and therapists.

Professional Component (PC) - When referencing billing/payment requirements, the physician's interpretation of the results of the examination.

Prospective Payment System (PPS) - System mandated by the Balanced Budget Act of 1997 (BBA); changes Medicare payments from cost-based to prospective, based on national average capital costs per case. PPS helps Medicare control its spending by encouraging providers to furnish care that is efficient, appropriate, and typical of practice expenses for providers. Beneficiary and resource needs are statistically grouped, and the system is adjusted for beneficiary characteristics that affect the cost of providing care. A unit of service is then established, with a fixed, predetermined amount for payment.

Prostate Specific Antigen (PSA) Blood Test - A test for the tumor marker for adenocarcinoma of the prostate that can help to predict residual tumor in the post-operative phase of prostate cancer.

Prosthetists - An individual who provides the best possible artificial replacement for patients who have lost or were born without a limb. A prosthetic limb should feel and look like a natural limb.

Provider - Any Medicare provider [e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA), Outpatient Physical Therapy (OPT), Comprehensive Outpatient Rehabilitation Facility (CORF), End-Stage Renal Disease (ESRD) facility, hospice, physician, qualified non-physician provider, laboratory, supplier] providing medical services covered under Medicare Part B. Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, Ambulatory Surgical Centers (ASCs), and outpatient clinics are some of the providers of services covered under Medicare Part B.

Q

Quantitative Computed Tomography (QCT) - Bone mass measurement most commonly used to measure the spine (but can also be used at other sites).

R

Reasonable Cost - The Centers for Medicare & Medicaid Services (CMS) guidelines used by Fiscal Intermediaries (FIs), carriers, and AB Medicare Administrative Contractors (AB MACs) to determine reasonable costs incurred by individual providers in furnishing covered services to enrollees.

Referral - A plan may restrict certain health care services to an enrollee unless the enrollee receives a referral from a plan-approved caregiver, on paper, referring them to a specific place/person for the service. Generally, a referral is defined as an actual document obtained from a provider in order for the beneficiary to receive additional services.

Regional Office - The Centers for Medicare & Medicaid Services (CMS) has 10 Regional Offices that work closely together with Medicare Contractors in their assigned geographical areas on a day-to-day basis. Four of these Regional Offices monitor network contractor performance, negotiate contractor budgets, distribute administrative monies to contractors, work with contractors when corrective actions are needed, and provide a variety of other liaison services to the contractors in their respective regions.

Remittance Advice (RA) - Statement sent to providers that explains the reimbursement decision made by the payment contractor. This explanation may include the reasons for payments, denials, and/or adjustments for processed claims. Also serves as a companion to claim payments.

Remittance Advice Claim Adjustment Reason and Remark Codes (RARCs) - Codes used within the American National Standards Institute (ANSI) X12N 835 Transaction to convey information about remittance processing or to provide a supplemental explanation for an adjustment.

Renal Dialysis Facility (RDF) - A unit (hospital based or freestanding) that is approved to furnish dialysis services directly to End-Stage Renal Disease (ESRD) beneficiaries.

Revenue Codes - Payment codes for services or items (e.g., 42X, 43X) found in Medicare and/or National Uniform Billing Committee (NUBC) manuals.

Roster Billing - Also referred to as simplified roster billing; a process developed by the Centers for Medicare & Medicaid Services (CMS) that enables entities that accept assignment, who administer the influenza virus and/or pneumococcal vaccine to multiple beneficiaries, to bill Medicare for payment using a modified CMS-1450 or CMS-1500 claim form.

Rural Health Clinic (RHC) - An outpatient facility that is primarily engaged in furnishing physicians and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the United States Bureau of Census.

S

Screening Diagnosis Code - A code assigned to the medical terminology used for each service and/or item provided by a provider or health care facility (as noted in the medical records) [e.g., the screening diagnosis code for preventive glaucoma screening is V80.1 (Special Screening for Neurological, Eye, and Ear Disease, Glaucoma)]. Diagnosis codes are based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

Screening Mammography - A mammogram performed on an asymptomatic female beneficiary to detect the presence of breast cancer at an early stage.

Single Energy X-ray Absorptiometry (SEXA) - A method of bone mass measurement that measures the wrist or heel.

Skilled Nursing Facility (SNF) - An institution or distinct part of an institution having a transfer agreement with one or more hospitals; primarily engaged in providing inpatient skilled nursing care or rehabilitation services.

Slit-Lamp Biomicroscopic Examination - An examination of the eye with a low-power binocular microscope placed horizontally and used with a slit lamp for detailed examination of the back part of the eye.

T

Technical Component (TC) - When referencing billing/payment requirements, all other services outside of the physician's interpretation of the results of the examination.

Type of Bill (TOB) Code - A three-digit numeric code that identifies what type of provider is billing and in what sequence. Not all providers use the third digit, which matches up with the patient status code (e.g., discharged).

U

United States Preventive Services Task Force (USPSTF) - An independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.

W

"Welcome to Medicare" Physical Exam - Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 expanded preventive services to include coverage, under Medicare Part B, of a one-time initial preventive physical examination (IPPE), also referred to as the "Welcome to Medicare Physical Exam" or the "Welcome to Medicare Visit" (WMV). Medicare beneficiaries whose Medicare Part B effective date began on or after January 1, 2005 are covered for a one-time IPPE visit. Effective January 1, 2009, the IPPE must be received within 12 months of their Medicare Part B effective date. The goals of the IPPE are health promotion and disease detection, and include education, counseling, end-of-life planning, and referral to screening and preventive services also covered under Medicare Part B.

World Health Organization (WHO) - An organization that maintains the International Classification of Diseases (ICD) medical code set.

X

X12N - An American National Standards Institute (ANSI)-accredited group that defines Electronic Data Interchange (EDI) standards for many American industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under HIPAA are X12 standards.

Notes

Notes

Reference C: Provider Educational Resources

Medicare Fee-For-Service (FFS) Provider Educational Products List

Please Note:

The products listed here are for provider use only and are not intended for distribution to Medicare beneficiaries. For a list of beneficiary reference materials, please see Reference F in this guide.

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals is part of a comprehensive provider education and information program designed to:

1. Ensure Medicare Fee-For-Service (FFS) providers have the information they need to properly bill for preventive services and screenings covered by Medicare; and
2. Promote increased awareness and utilization of these benefits and encourage providers to talk with their Medicare patients about prevention, early detection, and the importance of taking full advantage of Medicare preventive benefits for which they may be eligible.

In addition to The Guide, the Centers for Medicare & Medicaid Services has developed a variety of products to educate providers and their staff about coverage, coding, billing, and payment for Medicare preventive services and screenings, including:

- A Dedicated Educational Web Page ~ The Medicare Learning Network (MLN) Preventive Services Educational Products web page is a one-stop shop for provider educational information on coverage, coding, and billing of Medicare-covered preventive benefits. The web page contains a descriptive listing of the products, which include articles, a guide, brochures, quick reference charts, web-based training courses, a video program, seasonal flu information, and a bookmark, as well as product ordering information and links to other related CMS and non-CMS prevention resources and websites. http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp
- MLN Matters Articles ~ National articles specifically for health care professionals about Medicare preventive services and screenings.
- Quick Reference Information Charts ~ Quick Reference Information: Medicare Preventive Services; Medicare Preventive Services Quick Reference Information: Medicare Part B Immunization Billing; and Medicare Preventive Services Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination.
- A Series of 7 Brochures ~ Adult Immunizations; Bone Mass Measurements; Cancer Screenings; Diabetes-Related Services; Expanded Benefits; Glaucoma Screening; and Smoking and Tobacco-Use Cessation Counseling Services.
- A Series of 3 Web-based Training Courses ~ Medicare Preventive Services Series Web-based Training Courses (Parts 1, 2, and 3), each approved by CMS for continuing education credits for successful completion.

- An MPS Bookmark ~ a practical giveaway for providers that lists all of the preventive benefits covered by Medicare with a message to providers reminding them to talk with their Medicare patients about the preventive benefits.
- A Technical Guide ~ Determining a Medicare Beneficiary's Eligibility for Medicare Preventive Services.

Many of the print products are available in hardcopy and downloadable PDF internet files. Ordering information for all products listed here as well as links to on-line products can be found on the dedicated MLN Preventive Services Educational Products web page located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS website. **All products are available, free of charge, from the Medicare Learning Network.**

The charts on the following pages are for provider use only and are not intended for distribution to Medicare beneficiaries. On the next pages, you will find copies of the following provider resources:

- Quick Reference Information: Medicare Preventive Services
- Medicare Preventive Services Quick Reference Information: Medicare Part B Immunization Billing
- Medicare Preventive Services Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination
- Medicare Preventive Services Cost Sharing Information
- Medicare Preventive Services – Manual, Regulation, and MLN Matters Article References

(For information appropriate for beneficiary distribution, refer to the "Resources for Medicare Beneficiaries.")

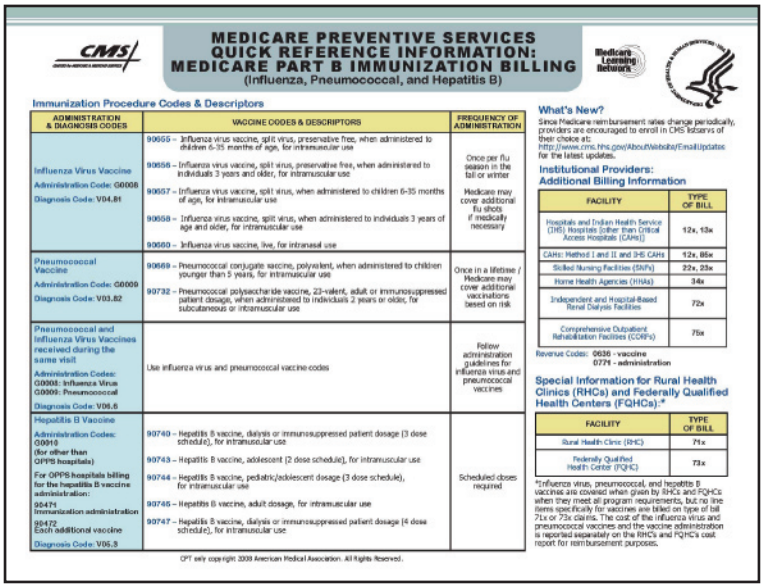
Quick Reference Information: Medicare Preventive Services

This chart provides quick reference to Medicare's preventive services.

This chart may be viewed, downloaded, and printed by clicking on the image. You can also access this chart online at the following link:

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

Medicare Preventive Services Quick Reference Information: Medicare Part B Immunization Billing

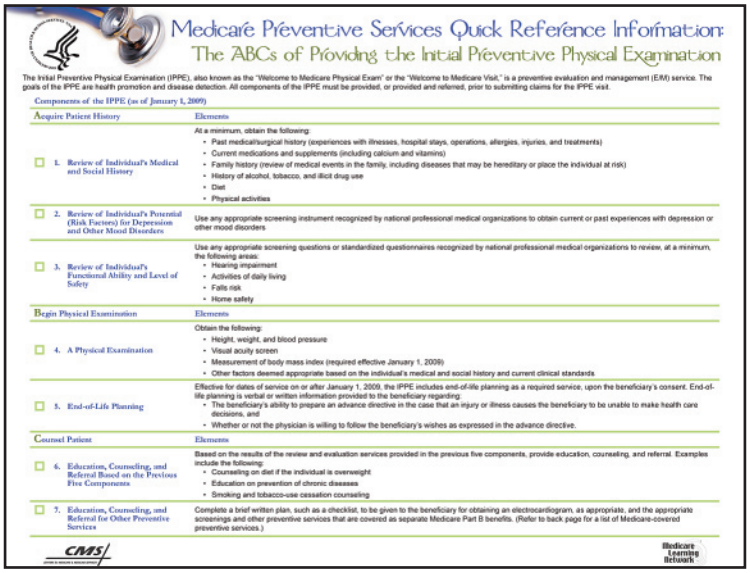


This chart provides quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration.

This chart may be viewed, downloaded, and printed by clicking on the image. You can also access this chart online at the following link:

http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf

Medicare Preventive Services Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination



This chart identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information.

This chart may be viewed, downloaded, and printed by clicking on the image. You can also access this chart online at the following link:

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

Table 1 – Medicare Preventive Services Cost Sharing Information

Preventive Benefit	Copayment/Coinsurance/Deductible
Initial Preventive Physical Examination (IPPE) /"Welcome to Medicare" Physical Exam	The beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible. For services performed on or after January 1, 2009, the deductible for the IPPE only is waived (not the screening EKG). The coinsurance/copayment still applies to both.
Abdominal Aortic Aneurysms (AAA) Ultrasound Screening	The beneficiary pays 20% of the Medicare-approved amount with no Part B deductible.
Cardiovascular Screening Blood Test	The beneficiary pays nothing for this benefit.
Diabetes Screening	The beneficiary pays nothing for this benefit.
Diabetes Glucose Monitors, Test Strips, and Lancets	The beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible.
Diabetes Self-Management Training (DSMT)	The beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible.

Preventive Benefit	Copayment/Coinsurance/Deductible
Screening Mammography	The beneficiary pays 20% of the Medicare-approved amount with no Part B deductible.
Medical Nutrition Therapy (MNT)	The beneficiary pays 20% of the Medicare-approved amount for services after the yearly Part B deductible.
Screening Pap Test	The beneficiary pays nothing for the Pap lab test. For the Pap test collection, the beneficiary pays 20% of the Medicare-approved amount with no Part B deductible.
Screening Pelvic Exam (includes a clinical breast exam)	The beneficiary pays 20% of the Medicare-approved amount with no Part B deductible.
Colorectal Cancer Screening	**Fecal Occult Blood Test** – The beneficiary pays nothing for this lab test. **All Other Screening Procedures** – The beneficiary pays 20% of the Medicare-approved amount. If the flexible sigmoidoscopy or colonoscopy is done in a hospital outpatient department, the beneficiary will pay 25% of the Medicare-approved amount. The Part B deductible is waived for the colorectal cancer screening benefit. The coinsurance/copayment still applies. **NOTE:** The deductible is not waived if a screening colorectal test becomes a diagnostic colorectal test.
Prostate Cancer Screening	**PSA** – The beneficiary pays nothing for this lab test. **DRE** – Generally the beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible.
Influenza Virus Vaccination	The beneficiary pays nothing for this benefit.
Pneumococcal Vaccination	The beneficiary pays nothing for this benefit.
Hepatitis B (HBV) Vaccination	The beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible.
Bone Mass Measurements	The beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible.
Glaucoma Screening	The beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible.
Smoking and Tobacco-Use Cessation Counseling Services	The beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible.

January 2009

Table 2 – Medicare Preventive Services – Manual, Regulation, and MLN Matters Article References

Benefit	Reference
Bone Mass Measurements	Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 80.5 http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf Medicare Claims Processing Manual – Pub. 100-04, Chapter 13, Section 140 http://www.cms.hhs.gov/manuals/downloads/clm104c13.pdf MLN Matters article MM5847, Clarification of Bone Mass Measurement (BMM) Billing Requirements Issued in CR 5521 http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5847.pdf MLN Matters article MM5521, Bone Mass Measurements (BMMs) http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5521.pdf
Cardiovascular Disease Screening	Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 100 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 612 http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf
Colorectal Cancer Screening	Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 280.2 http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 60 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf MLN Matters article MM6145, Screening DNA Stool Test for Colorectal Cancer http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6145.pdf
Diabetes Screening	Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 90 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 613 http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf MLN Matters article MM6215, Adding Certain Entities as Originating Sites for Payment of Telehealth Services--Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6215.pdf MLN Matters article MM5895, Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5895.pdf MLN Matters article SE0821, Reminder – Medicare Provides Coverage of Diabetes Screening Tests http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0821.pdf

Benefit	Reference
Diabetes Self-Management Training (DSMT)	Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 300 http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 120 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf MLN Matters article 5433, Guidelines for Payment of Diabetes Self-Management Training (DSMT) http://www.cms.hhs.gov/MLNMattersArticles/Downloads/mm5433.pdf
Glaucoma Screening	Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 280.1 http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 70 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf
Immunizations (Influenza Virus, PPV, and HBV)	Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 10 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf MLN Matters article MMSE0838, 2008 – 2009 Influenza (Flu) Season Resources for Health Care Professionals http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf MLN Matters article MM6153, Influenza Vaccine and the Pneumococcal Vaccine Payment Allowances Based on 95 Percent of the Average Wholesale Price (AWP) http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6153.pdf MLN Matters article MM6079, Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6079.pdf MLN Matters article MM6121, 2008 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6121.pdf MLN Matters article MM5910, 2008 Clarification to CR 5744 – Payment Allowance Update for the Influenza Virus Vaccine CPT 90660 and further instruction regarding the Pneumococcal Vaccine CPT 90669 http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5910.pdf MLN Matters article MM5511, Update to Medicare Claims Processing Manual (Publication 100-04), Chapter 18, Section 10 for Part B Influenza Billing http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf

Benefit	Reference
Initial Preventive Physical Examination (IPPE)	Medicare Claims Processing Manual – Pub. 100-04, Chapter 12, Section 30.6.1.1 http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 80 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 611 http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf MLN Matters article MM6223, Update to the Initial Preventive Physical Examination (IPPE) Benefit http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6223.pdf
Mammography Services	Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 280.3 http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 20 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf MLN Matters article MM6237, Reporting National Provider Identifiers (NPI) on claims for Out-of-Jurisdiction Purchased Mammography Preventive Screening and Diagnostic Services http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6237.pdf MLN Matters article MM6023, Instructions for Institutional Providers and Suppliers Billing Self-Referred Mammography Claims Regarding the Attending/Referring Physician National Provider Identifier (NPI) http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6023.pdf
Medical Nutrition Therapy (MNT)	Medicare Claims Processing Manual – Pub. 100-04, Chapter 4, Section 300 http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf
Pap Test	Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 280.4 http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 30 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf
Pelvic Examination	Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 40 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf MLN Matters article MM6085, Screening Pelvic Examination http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6085.pdf

Benefit	Reference
Prostate Cancer Screening	Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 50 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf
Smoking and Tobacco-Use Cessation Counseling Services	Medicare Claims Processing Manual – Pub. 100-04, Chapter 32, Section 12 http://www.cms.hhs.gov/manuals/downloads/clm104c32.pdf MLN Matters article MM6163, Smoking and Tobacco Use Cessation Counseling Billing Code Update for Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Physical Therapy Providers (OPTs) http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6163.pdf MLN Matters article MM5878, Smoking and Tobacco Use Cessation Counseling Billing Update to Medicare http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5878.pdf
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 110 http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Notes

Reference D: Centers for Medicare & Medicaid Services (CMS) Websites and Contact Information

Table 1 – CMS Websites

Resource	Website
Clinical Laboratory Improvement Amendment (CLIA)	http://www.cms.hhs.gov/clia
CMS Acronym List	http://www.cms.hhs.gov/apps/acronyms
CMS Adult Immunizations Website	http://www.cms.hhs.gov/AdultImmunizations
CMS Beneficiary Notices Initiative (BNI)	http://www.cms.hhs.gov/BNI
CMS Carrier/Fiscal Intermediary Toll-Free Number Directory	http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip
CMS Clinical Laboratory Fee Schedule Information	http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp
CMS Contact Information	http://www.cms.hhs.gov/ContactCMS
CMS Coverage Database	http://www.cms.hhs.gov/mcd/search.asp
CMS E-Mail Updates	Subscribe to an email update list to receive the latest CMS news: https://subscriptions.cms.hhs.gov/service/multi_subscribe.html?code=USCMS&custom_id=566
CMS Electronic Claim Submission Information	http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp
CMS Fee-For-Service (FFS) Provider Listservs	Subscribe to the most appropriate FFS provider listserv: http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/downloads/Provider_Listservs.pdf
CMS Forms	http://www.cms.hhs.gov/CMSForms CMS-1500: http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp CMS-1450: http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Resource	Website
CMS Glossary	http://www.cms.hhs.gov/apps/glossary
CMS Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) Information	http://www.cms.hhs.gov/MedHCPCSGenInfo
CMS Home Page	http://www.cms.hhs.gov
CMS ICD-9-CM Coordination and Maintenance Committee	http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp
CMS Medicare Contracting Reform	http://www.cms.hhs.gov/MedicareContractingReform
CMS Medicare Fee-For-Service Provider/Supplier Enrollment	http://www.cms.hhs.gov/MedicareProviderSupEnroll
CMS Medicare Fee-For-Service Provider/Supplier Enrollment Forms	http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp
CMS Online Manual System	http://www.cms.hhs.gov/manuals
CMS Prevention Web Pages	http://www.cms.hhs.gov/home/medicare.asp
CMS Quality Initiatives	http://www.cms.hhs.gov/QualityInitiativesGenInfo
CMS Regional Offices - Information for Professionals	http://www.cms.hhs.gov/consortia
Documentation Guidelines for Evaluation and Management Services	http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp
Medicaid - list of State Health Departments	http://www.cms.hhs.gov/apps/contacts/default.asp
Medicare Claims Processing Manual	http://www.cms.hhs.gov/manuals
Medicare Fee-For-Service Providers Website	http://www.cms.hhs.gov/center/provider.asp
Medicare Learning Network (MLN)	http://www.cms.hhs.gov/MLNGenInfo

Resource	Website
Medicare Learning Network Influenza (Flu) Season Educational Products and Resources	http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf
Medicare Modernization Update	http://www.cms.hhs.gov/MMAUpdate
Medicare Physician Fee Schedule (MPFS)	http://www.cms.hhs.gov/PhysicianFeeSched
Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 - Summary of the MMA	http://www.cms.hhs.gov/MMAUpdate
Medicare Preventive Benefits Outreach Materials for Providers	http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp
Medicare Preventive Services General Information	http://www.cms.hhs.gov/PrevntionGenInfo
MLN Matters Articles	http://www.cms.hhs.gov/MLNMattersArticles
National Correct Coding Initiative Edits Website	http://www.cms.hhs.gov/NationalCorrectCodInitEd
National Provider Identifier Information	http://www.cms.hhs.gov/NationalProvIdentStand
Open Door Forums	These free events/teleconferences provide an opportunity for live dialogue between CMS and the community. http://www.cms.hhs.gov/OpenDoorForums
Outpatient Prospective Payment System (OPPS)	http://www.cms.hhs.gov/HospitalOutpatientPPS
Physician Center Web Page	http://www.cms.hhs.gov/center/physician.asp
Physician Fee Schedule Federal Regulation Notices	http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/list.asp
Remittance Advice Information	http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

Table 2 – Health Insurance Portability and Accountability (HIPAA) Contact Information

Resource	Contact Information
CMS Health Insurance Portability and Accountability Act of 1996 (HIPAA) Website	http://www.cms.hhs.gov/HIPAAGenInfo
CMS HIPAA Experts - E-mail Address	AskHIPAA@cms.hhs.gov
HIPAA Administrative Simplification Hotline	1-866-282-0659
The Strategic National Implementation Process (SNIP) Website	http://www.wedi.org/snip/index.shtml
Designated Standard Maintenance Organizations (DSMOs) Website	http://www.hipaa-dsmo.org

Table 3 – CMS Contact Information

CMS Baltimore Headquarters	Contact Information
Centers for Medicare & Medicaid Services Central Office	Toll Free:1-877-267-2323 Local: 410-786-3000 TTY Toll-Free: 1-866-226-1819 TTY Local: 410-786-0727

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Reference E: Other Useful Websites

The following websites and contact information may be useful to providers interested in further information on preventive services and certain diseases and conditions mentioned throughout this Guide.

Resource	Website
Administration on Aging	http://www.aoa.gov/
Advisory Committee on Immunization Practices Website	http://www.cdc.gov/vaccines/recs/acip/default.htm
Agency for Healthcare Research and Quality (AHRQ)	http://www.ahrq.gov
American Academy of Ophthalmology (AAO)	http://www.aao.org
American Cancer Society (ACS)	http://www.cancer.org
American Cancer Society's Cancer Facts and Figures 2008	http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf
American Cancer Society's "How to Increase Colorectal Cancer Screening Rates In Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide"	http://www.cancer.org/docroot/PRO/PRO_4_ColonMD.asp
American Diabetes Association (ADA)	http://www.diabetes.org
American Dietetic Association	http://www.eatright.org
American Heart Association	http://www.americanheart.org
American Lung Association	http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=22542
American Lung Association Flu Clinic Locator Website	http://www.fluclinicslocator.org
American Thoracic Society (ATS)	http://www.thoracic.org
The Association for Prevention Teaching and Research	http://www.atpm.org
Breast Cancer Facts & Figures 2007-2008	http://www.cancer.org/downloads/STT/BCFF-Final.pdf
Breast Cancer (PDQ®) Prevention	http://www.cancer.gov/cancertopics/pdq/prevention/breast/Patient/page2

Resource	Website
Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov
Centers for Disease Control and Prevention (CDC): Cervical Cancer	http://www.cdc.gov/cancer/cervical/basic_info/screening
Centers for Disease Control and Prevention (CDC): Smoking & Tobacco Use	http://www.cdc.gov/tobacco/
Centers for Disease Control and Prevention (CDC): Vaccines & Immunizations	http://www.cdc.gov/vaccines
Department of Health and Human Services (DHHS)	http://www.hhs.gov
Everyday Choices	http://www.everydaychoices.org
Eye Care America	http://www.eyecareamerica.org
Food and Drug Administration (FDA) List of Mammography Facilities	http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm
Food and Drug Administration (FDA) Mammography	http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram
The Glaucoma Foundation Website	http://www.glaucomafoundation.org
ICD-9-CM	http://www.cdc.gov/nchs/about/otheract/icd9/abticd9.htm
HealthierUS.gov	The HealthierUS initiative is a national effort to improve people's lives, prevent and reduce the costs of disease, and promote community health and wellness. The site encourages people to learn how to make physical activity a part of their day, eat healthy, protect themselves and their family from illness, and avoid risks to their health and the health of their loved ones. http://www.healthierus.gov/
The Immunization Action Coalition (IAC)	http://www.immunize.org
Indian Health Services	http://www.ihs.gov/

Resource	Website
Infectious Diseases Society of America (IDSA)	http://www.idsociety.org
Influenza Fact Sheet	http://www.lungusa.org/site/apps/nlnet/content3.aspx?c=dvLUK9O0E&b=2060161&content_id={FCF44717-3F12-400E-A34B-0EA3B7F89EDE}&notoc=1
Level I Current Procedural Terminology (CPT) Book Level II Healthcare Common Procedure Coding System (HCPCS) Book International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Diagnosis Coding Book	Order online by visiting the American Medical Association Press Online Catalog at https://catalog.ama-assn.org/Catalog/home.jsp on the Web. Toll free: 800-621-8335
List of Claims Adjustment Reason and Remark Codes	http://www.wpc-edi.com/Codes
Lung Disease Data at a Glance: Influenza and Pneumonia	http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=316591
Medicare Learning Network Influenza (Flu) Season Educational Products and Resources	http://www.cms.hhs.gov/MLNProducts/Downloads/Flu_Products.pdf
Medicare Quality Improvement Community (MedQIC)	http://medqic.org/dcs/ContentServer?pagename=Medqic/MQPage/Homepage
The Medline Plus Health Information Website	http://www.nlm.nih.gov/medlineplus
National Alliance for Hispanic Health	http://www.hispanichealth.org/
National Cancer Institute (NCI)	http://www.cancer.gov
National Cancer Institute (NCI): Breast Cancer: Screening & Testing	http://www.cancer.gov/cancerinfo/screening/breast
The National Cancer Institute's Colorectal Cancer Prevention (PDQ®)	http://www.nci.nih.gov/cancertopics/pdq/prevention/colorectal/Patient/page2

Resource	Website
National Diabetes Education Program	http://www.ndep.nih.gov/
National Diabetes Information Clearinghouse (NDIC)	http://diabetes.niddk.nih.gov
National Eye Institute (NEI)	http://www.nei.nih.gov
National Eye Institute Medicare Benefits: Resources	http://www.nei.nih.gov/medicare
The National Foundation for Infectious Diseases (NFID)	http://www.nfid.org
National Heart, Lung, and Blood Institute (NHLBI)	http://www.nhlbi.nih.gov
National Institute of Arthritis and Musculoskeletal and Skin Diseases	http://www.niams.nih.gov/Health_Info/Bone/default.asp#op
National Institutes of Health Tobacco Control Research	http://dccps.nci.nih.gov/tcrb
National Network for Immunization Information (NNII)	http://www.immunizationinfo.org
National Vaccine Program Office Website	http://www.hhs.gov/nvpo/
Office of the U.S. Surgeon General Tobacco Cessation Guidelines	http://www.surgeongeneral.gov/tobacco/default.htm
Partnership for Prevention	http://www.prevent.org
Prevent Blindness America Website	http://www.preventblindness.org
Prostate Cancer Screening: A Decision Guide	http://www.cdc.gov/cancer/prostate/informed_decision_making.htm
The Prostate-Specific Antigen (PSA) Test: Questions and Answers	http://www.cancer.gov/cancertopics/factsheet/Detection/PSA
Smokefree.gov	http://www.smokefree.gov
Social Security Administration	http://www.socialsecurity.gov/
Society for Vascular Surgery	http://www.vascularweb.org

Resource	Website
U.S. Administration on Aging	http://www.aoa.gov/
U.S. Preventive Services Task Force (USPSTF)	http://www.ahrq.gov/clinic/uspstfix.htm
U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services	http://www.ahrq.gov/clinic/cps3dix.htm
Washington Publishing Company (WPC) Code Lists	http://www.wpc-edi.com/Codes

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Reference F: Resources for Medicare Beneficiaries

The following websites and contact information may be useful to beneficiaries interested in further information on Medicare benefits and services.

Resource	Website/Contact Information
Administration on Aging	http://www.aoa.gov/
Find Medicare Beneficiary Publications	This site allows beneficiaries to search for publications that contain helpful information about Medicare benefits. http://www.medicare.gov/Publications/Search/SearchCriteria.asp?version=default&browser=IE%7C6%7CWinXP&Language=English&pagelist=Home&comingFrom=13
Medicare Beneficiary Help Line and Website	To obtain general Medicare information, order Medicare publications, get health plan information, and much more, beneficiaries can visit http://www.medicare.gov, or they can call 1-800-MEDICARE 24 hours a day, 7 days a week for assistance. Telephone: Toll-Free: 1-800-MEDICARE (1-800-633-4227) TTY Toll-Free: TTY 1-877-486-2048 Website: http://www.medicare.gov
Medicare.gov Home Page	The official U.S. Government website for people with Medicare. http://www.medicare.gov
Medicare and You Publication	http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf
Medicare Prescription Drug Coverage	Includes basic information about Medicare prescription drug coverage, drug plan finder, formulary (drug) finder, and enrollment center. http://www.medicare.gov/pdphome.asp
MyMedicare.gov	This website is a one-stop, user-friendly website that gives registered Medicare beneficiaries access to personalized information on benefits and services that are available to them. http://www.mymedicare.gov
Preventive Services: A Healthier US Starts Here	http://www.medicare.gov/Health/Overview.asp

Resource	Website/Contact Information
Social Security Administration	http://www.ssa.gov/
State Health Insurance Assistance Program (SHIP)	This website provides contact information for State SHIP offices. Local SHIPs provide health insurance counseling and information to Medicare beneficiaries through free personalized, face-to-face counseling and assistance via telephone, public education presentations and programs, and media activities. http://www.medicare.gov/Contacts/staticpages/ships.aspx

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Reference G: Advance Beneficiary Notice of Noncoverage (ABN)

What Is An Advance Beneficiary Notice of Noncoverage (ABN)?

An ABN is a written notice that a provider or supplier gives to a Medicare beneficiary. The purpose of the ABN is to inform a beneficiary, before he or she receives specified items or services that otherwise might be paid for by Medicare, that Medicare probably will not pay on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance.

Frequently, there is confusion regarding whether an ABN can be used to shift liability to a beneficiary for the cost of non-covered items or services. In making this decision, the provider/supplier first must determine whether the item or service meets the definition of the Medicare-covered benefit. If the item or service does not meet the definitional requirements for the Medicare-covered benefit, then the item or service will never be covered by Medicare. As a result, the beneficiary will always be liable for the cost of the item or service, and an ABN is not needed to shift liability to the beneficiary.

If the item or service meets the definition of the Medicare-covered benefit, Medicare still may not pay for the item or service if the item or service was "not reasonable and necessary" for the beneficiary on the occasion in question, or if the item or service exceeds the frequency limitation for the particular benefit or falls outside the applicable time frame for receipt of the covered benefit. In these instances, an ABN may be used to shift liability for the cost of the item or service to the beneficiary. If an ABN is not issued to the beneficiary, the provider/supplier may be held liable for the cost of the item or service unless the provider/supplier is able to demonstrate that they did not know and could not reasonably have been expected to know that Medicare would not pay for the item or service.

Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), Formerly the Advance Beneficiary Notice, Announcement

On Monday, March 3, 2008, CMS implemented the use of the revised Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131). This form replaces the General Use ABN (CMS-R-131-G), and the Lab ABN (CMS-R-131-L) for physician-ordered laboratory tests. The form (English and Spanish versions) and notice instructions are now posted on the Beneficiary Notice Initiative web page (http://www.cms.hhs.gov/bni/) on the CMS website. Please be advised that the ABN-G and ABN-L are no longer valid as of March 1, 2009.

The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) Program for items and services that they provide under Medicare Part A (hospice and religious non-medical healthcare institutions only) and Part B. It may not be used for items or services provided under the Medicare Advantage Program, or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).

The revised ABN [which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and Notice of Exclusion from Medicare Benefits (NEMB) (CMS-20007)] will now be used to fulfill both mandatory and voluntary notice functions.

Note: Skilled Nursing Facilities (SNFs) must use the revised ABN for all items and services billed to Part B. However, once the revised SNF ABN is implemented, SNFs must use the revised SNF ABN for all items and services billed to both Part A and Part B.

Mandatory ABN Use

The following situations require by statute that an ABN be issued:

- Care is not reasonable and necessary;
- There is a violation of the prohibition on unsolicited telephone contacts;
- Medical equipment and supplies supplier number requirements are not met;
- Medical equipment and/or supplies are denied in advance;
- Custodial care; and
- A hospice patient who is not terminally ill.

Voluntary ABN Use

In the following situations, the issuance of an ABN is voluntary:

ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e., care that is never covered) or fails to meet a technical benefit requirement (i.e., lacks required certification), but may be used voluntarily.

The following are examples in which the ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered:

- Care that fails to meet the definition of a Medicare benefit as defined in Section 1861 of the Social Security Act;
- Care that is explicitly excluded from coverage under Section 1862 of the Social Security Act. Examples include:
  - Services for which there is no legal obligation to pay;
  - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual eligibles);
  - Services required as a result of war;
  - Personal comfort items;
  - Routine physicals (except the initial preventive physical examination or "Welcome to Medicare" physical examination) and most screening tests;
  - Routine eye care;
  - Dental care; and
  - Routine foot care.

ABN issuers [who may be physicians, practitioners, providers (including laboratories), suppliers, Medicare Contractors, or utilization review committees for the care provider] are collectively known as "notifiers."

- Notifiers may direct an employee or a subcontractor to actually deliver an ABN; however, the notifier remains ultimately responsible for its effective delivery.
- Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three "triggering events" during a course of treatment (initiation, reduction, and termination).
- Notifiers must give an ABN to "recipients" (FFS Medicare beneficiaries or their representatives), including beneficiaries who have Medicaid coverage in addition to Medicare (i.e., dual eligible). Providers should note that a notifier's inability to give notice to a beneficiary or his/her representative does not allow them to shift financial liability to the beneficiary, unless they have exhausted all attempts to issue the notice, and such attempts are clearly documented in the beneficiary's record and undisputed by the beneficiary.

For dates of service beginning March 3, 2008, and prior to March 1, 2009, Medicare Contractors will accept either the current ABN-G and ABN-L or the revised ABN as valid notification.

For dates of service beginning March 1, 2009, Medicare Contractors will accept only a properly executed revised ABN (CMS R-131) as valid notification.

For More Information

- You can find more information about the revised ABN Form (CMS-R-131) by reviewing Change Request CR 6136, located at http://www.cms.hhs.gov/Transmittals/downloads/R1587CP.pdf on the CMS website. This CR contains the updated Medicare Claims Processing Manual Chapter 30 (Financial Liability Protections), Section 50 [Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)] as an attachment to the CR.
- The related MLN Matters article can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6136.pdf on the CMS website.
- If you have any questions, please contact your carrier, FI, RHHI, AB MAC, or DME MAC at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.
- Additional information on the revised ABN and other limitation of liability notices can be found on the Beneficiary Notice Initiatives web page at http://www.cms.hhs.gov/bni/ on the CMS website. Questions regarding the revised ABN can be emailed to RevisedABN_ODF@cms.hhs.gov at CMS.

Notes

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