
HCFA Rulings

Department of Health
and Human Services

Health Care Financing
Administration

Ruling No. 96-2

Date: November 1996

HCFA Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, and related matters.

HCFA Rulings are binding on all HCFA components, Medicare contractors, the Office of Hearings, the Medicare Geographic Classification Review Board, the Departmental Appeals Board, and Administrative Law Judges who hear Medicare appeals. These decisions promote consistency in interpretation of policy and adjudication of disputes.

This Ruling states the policy of the Health Care Financing Administration concerning the requirements for determining if Medicare payment will be made under the limitation on liability provision, section 1879 of the Social Security Act, to a supplier, practitioner, or other supplier for pap smears and mammography services for which Medicare payment is denied.

HCFA 96-2-1

MEDICARE PROGRAM

Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B)

REQUIREMENTS FOR DETERMINING LIMITATION ON LIABILITY OF A MEDICARE BENEFICIARY, SUPPLIER, PRACTITIONER, OR OTHER SUPPLIER FOR PAP SMEARS AND MAMMOGRAPHY SERVICES FOR WHICH MEDICARE PAYMENT IS DENIED.

PURPOSE: This Ruling states the policy of the Health Care Financing Administration concerning the requirements for determining if Medicare payment will be made under the limitation on liability provision, section 1879 of the Social Security Act, to a supplier, practitioner, or other supplier for pap smears and mammography services for which Medicare payment is denied.

CITATIONS: Sections 1142, 1154, 1814, 1815, 1833, 1834, 1842, 1861, 1862, 1866, and 1879 of the Social Security Act (42 U.S.C. 1320b-12, 1320c, 1395f, 1395g, 1395l, 1395m, 1395u, 1395x, 1395y, 1395cc, and 1395pp), 42 CFR 411.400, 411.402, 411.404, 411.406, and HCFA 95-1.

RULING APPLICABLE TO DETERMINING LIMITATION ON LIABILITY OF A MEDICARE BENEFICIARY, SUPPLIER, PRACTITIONER, OR OTHER SUPPLIER FOR PAP SMEARS AND MAMMOGRAPHY SERVICES FOR WHICH MEDICARE PAYMENT IS DENIED

I. BACKGROUND

Section 1879 of the Social Security Act (the Act) provides financial relief to beneficiaries, suppliers, practitioners, and other suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare payment would otherwise be denied. We refer to this section of the Act as "the limitation on liability provision."

The purpose of this Ruling is to provide a detailed clarification of our policy with regard to the limitation on liability provision as it applies to pap smears and mammography services to ensure that Medicare payment under the policy is made in an appropriate and consistent manner. This Ruling supplements and extends HCFA Ruling 95-1.

II. COVERAGE DENIALS TO WHICH THE LIMITATION ON LIABILITY PROVISION APPLIES - STATUTORY BASES

A coverage determination for an item or service must be made before there can be a decision with respect to whether Medicare payment may be made under the limitation on liability provision. Medical review entities, acting for the Secretary, are authorized to make the coverage determinations. These entities include fiscal

intermediaries, carriers, and Utilization and Quality Control Peer Review Organizations. In this Ruling, we refer to these entities collectively as Medicare contractors. These entities must act in accordance with the Medicare statutes, regulations, national coverage instructions, accepted standards of medical practice, and HCFA Rulings when making coverage determinations.

The claims payment and beneficiary indemnification provisions (sections 1879(a) and (b)) of the limitation on liability provision are applicable only to claims for beneficiary items or services submitted by providers, or by practitioners and other suppliers that have taken assignment. These provisions are applicable only to claims for services, not otherwise statutorily excluded, that are denied on the basis of section 1862(a)(1), 1862(a)(9), 1879(e), or 1879(g) of the Act. Under current law, section 1862(a)(1) includes, in section 1862(a)(1)(F), screening mammography that is performed more frequently than is covered under section 1834(c)(2) or that is not conducted by a facility described in section 1834(c)(1)(B) and screening pap smears performed more frequently than is provided for under section 1861(nn).

Screening (as distinguished from diagnostic) mammography is defined in section 1861(jj); the frequency criterion for coverage is a provision of section 1834(c)(2); and the proper facility criterion is a provision of

HCFAR 96-2-4

section 1834(c)(1)(B). Screening pap smears are defined in section 1861(nn) and the frequency criterion for coverage is part of that definition. Nonetheless, the statutory basis of denial for screening mammography services which exceed the frequency criterion and/or fail the proper facility criterion, and for screening pap smears which exceed the frequency criterion, is section 1862(a)(1)(F) and, accordingly, limitation on liability under section 1879 applies to all such denials.

Section 1862(a)(1)(F) does not apply to diagnostic mammography claims. Limitation on liability under section 1879 applies to claims for diagnostic mammography services, if submitted under an assignment of benefits and denied under section 1862(a)(1)(A) as not reasonable and necessary.

If a screening mammogram is furnished to a beneficiary erroneously, that is, if the ordering physician, in fact, intended that a diagnostic mammogram be furnished, the statutory basis of denial depends upon the circumstances of the case. If the screening mammogram can be denied for failing the frequency criterion for coverage under section 1834(c)(2) and/or the proper facility criterion under section 1834(c)(1)(B), the claim must be denied on the basis of section 1862(a)(1)(F). If the claim cannot be denied on the basis of section 1862(a)(1)(F), the claim must be denied on the basis of section 1862(a)(1)(A) as not reasonable and necessary. Limitation on liability under section 1879 would

HCFAR 96-2-5

apply to any denial under either section 1862(a)(1)(F) or section 1862(a)(1)(A). In any such instance of an erroneously furnished screening mammogram, a beneficiary cannot be held liable by virtue of the provision to the beneficiary of an advance written notice of noncoverage, since the supplier/mammography center erred in providing a screening mammogram in the first place, a fact of which the beneficiary would have to be aware in order to be able to actually make an informed consumer decision to receive the screening mammogram. In all such instances of erroneously furnished screening mammograms, the supplier/mammography center is liable under section 1879 because it is expected to know that an order from a physician for a mammography service must specifically prescribe either a screening or diagnostic mammogram is to be performed, and that furnishing a screening mammogram when a diagnostic mammogram is prescribed is not covered by reason of section 1862(a)(1)(A), even if it otherwise could be covered under section 1862(a)(1)(F).

While this Ruling deals primarily with assignment-related claims and section 1879, whereby Medicare payment may be made or the beneficiary may be indemnified under certain circumstances, the following policy is noteworthy. For unassigned

claims, the relevant liability protection issue is the applicability of the refund requirements of section 1842(l) which apply only to

HCFAR 96-2-6

physicians' services. Section 1848(j)(3) defines "physicians' services" for the purposes of section 1848, "Payment for Physicians' Services." Section 1848(j)(3) provides that the diagnostic x-ray tests, including diagnostic mammography, described in section 1861(s)(3), are physicians' services.

Therefore, because diagnostic mammography services are considered physicians' services, the refund requirements of section 1842(l) apply to claims for diagnostic mammography services submitted on an unassigned basis and denied under section 1862(a)(1)(A) as not reasonable and necessary. The physician or supplier/mammography center which furnishes a diagnostic mammography service may be required to make refund under section 1842(l). Where the service was ordered, but was not furnished, by an attending physician, the ordering physician cannot be required to make refund. Screening mammography is defined in section 1861(jj), not in section 1861(s)(3), and, therefore, is not a physicians' service. Because screening mammography is not considered a physicians' service, however, the refund requirements of section 1842(l) do not apply to claims for screening mammography services submitted on an unassigned basis and denied as not reasonable and necessary. Furthermore, limitation on liability under section 1879 cannot be applied to such denied unassigned claims for screening mammography services on the basis of a denial under either section

HCFAR 96-2-7

1862(a)(1)(A) or section 1862(a)(1)(F), because the claims are unassigned.

Virtually all pap smears (both technical and professional components) are clinical diagnostic laboratory tests. Assignment is taken on all such pap smears, whether furnished under the diagnostic pap smear benefit or the screening pap smear benefit, because all clinical diagnostic laboratory tests must be assigned. Therefore, section 1842(l) is never applied to any such pap smear denials. Section 1879 may be applied to denials under section 1862(a)(1)(F) of screening pap smears which exceed the frequency criterion in section 1861(nn), and to denials of any pap smear (whether diagnostic or screening) found to be not reasonable and necessary under section 1862(a)(1)(A).

Solely in the case of a pap smear (diagnostic or screening) furnished to a hospital inpatient, if the physician bills for the professional component (e.g., interpretation) of the test as a physicians' service, that claim may be submitted on an unassigned basis; in which case, limitation on liability under section 1879 cannot be applied to denials of any such unassigned claims, but section 1842(l) may apply if the claim is denied under section 1862(a)(1).

HCFAR 96-2-8

III. EFFECTIVE DATE

This Ruling is effective *November 6 , 1996.*

Dated: *November 6, 1996*

**Bruce C. Vladeck,
Administrator,
Health Care Financing
Administration**



[Return to Rulings](#)