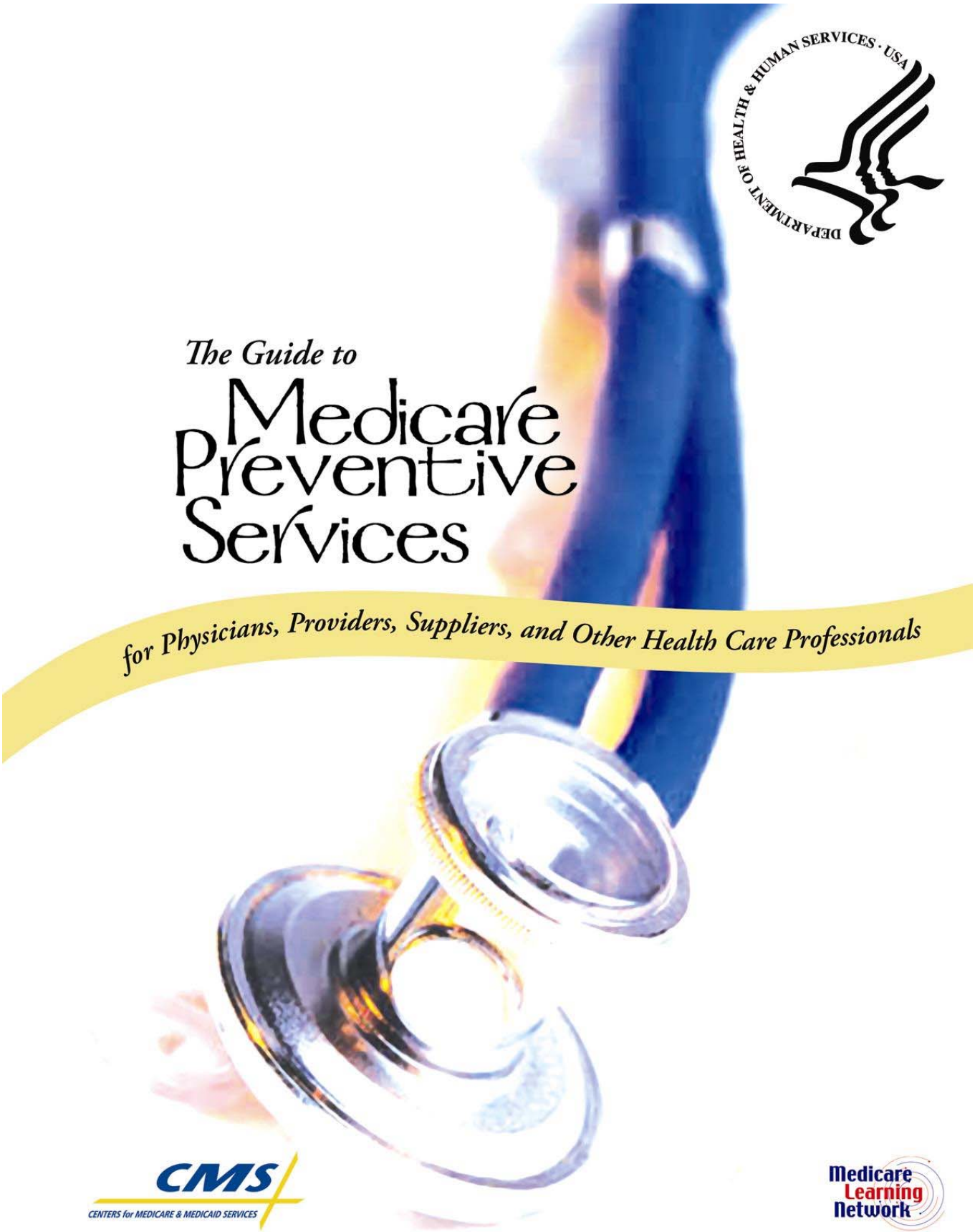

The Guide to

Medicare Preventive Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Learning Network

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The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals

January 2005

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The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals has been prepared as a service to the public and is not intended to grant rights or impose obligations. This Guide may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

ICD-9 Notice

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The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare providers. For additional information visit the Medicare Learning Network's Medlearn web page at www.cms.hhs.gov/medlearn.

Medicare Expands Preventive Benefits for Seniors

Every year, hundreds of thousands of Americans die prematurely from diseases that are preventable through immunization or amendable through early detection, treatment, and lifestyle changes. The good news is that every year the statistics improve. Some of this improvement can be contributed to an increased national focus on early detection and promotion of prevention and screening services.

Prior to the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the Medicare Program provided coverage for many preventive services, including: annual mammography screening, increased access to Pap tests and pelvic exams, colorectal and prostate cancer screening, glaucoma screening, diabetes self-management, medical nutritional therapy, and bone mass measurement. The MMA further expanded preventive services for Medicare beneficiaries to include an initial preventive physical examination (IPPE), i.e., "Welcome to Medicare" physical examination, coverage for cardiovascular screening blood tests, and coverage for diabetes screening tests. The inclusion of these new benefits continues the Centers for Medicare & Medicaid Services' (CMS') effort to move Medicare toward a prevention-oriented program.

This national focus on prevention and early detection has resulted in a higher level of consumer interest in preventive medicine and a greater need for information on Medicare coverage of these preventive services. CMS is taking significant steps to reach out and educate both the provider community and beneficiaries about the array of preventive services and screenings Medicare covers for eligible beneficiaries. "*The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals"* is one resource that CMS has prepared for the provider community as part of a comprehensive program to promote awareness and increase utilization of these benefits. This guidebook also provides coverage, coding, billing, and payment information to help you file claims effectively. Complimentary resources on Medicare prevention-related benefits, such as web-based training courses, brochures, and other educational products for providers can be found on the *Medicare Learning Network's* website at www.cms.hhs.gov/medlearn.

CMS recognizes the crucial role that health care providers play in promoting, providing, and educating Medicare patients about these beneficial preventive services and screenings. We need your help to convey the message that prevention, early detection, disease management, and lifestyle changes can help improve the quality of life for Medicare beneficiaries. The "Welcome to Medicare" physical examination presents a new opportunity for you to share with your Medicare patients information about prevention and screening services for which they may be eligible and encourages utilization of these benefits as appropriate. With your help we will be able to deliver the best possible healthcare to Medicare beneficiaries and continue our initiative toward a prevention-oriented program. For beneficiary-related information, you or your patients may visit www.medicare.gov and/or call 1-800-MEDICARE (1-800-633-4227).

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.

PREFACE

❖ WHY PREVENTION IS IMPORTANT

Preventive screenings and services, early detection of disease, and disease management, along with professional advice on diet, exercise, weight control, and smoking cessation, can help beneficiaries lead healthier lives and prevent, delay, or lessen the impact of disease.

The Centers for Medicare & Medicaid Services (CMS) continues with its initiative to help Medicare beneficiaries lead healthier lives through a comprehensive health care program, and to make Medicare a prevention-focused program. Specifically, CMS coverage rules, as governed by statute and regulations, are designed to support Federal health initiatives such as:

- Healthy People 2010 (www.healthypeople.gov)
- Steps to a Healthier US (www.healthierus.gov)
- The Secretary's Diabetes Detection Initiative (www.ndep.nih.gov/ddi/)

Heart disease, cancer, stroke and diabetes cause the most deaths of people with Medicare, but each disease can be prevented or treated more effectively when found earlier. In addition to the many Federal initiatives to promote awareness of preventive services, the Centers for Medicare & Medicaid Services has joined the American Cancer Society, the American Diabetes Association, and the American Heart Association to help get the word out about the prevention and early detection services covered by Medicare. These groups have also joined together to start a public awareness campaign, “Everyday Choices for a Healthier Life,”™ which is focused on helping all Americans lower their risk of cancer, diabetes, heart disease, and stroke by taking charge of their everyday choices. To find out more about the “Everyday Choices” campaign or how to lower your risk for these four diseases, visit www.everydaychoices.org or call 1-866-399-6789.

❖ NEW PREVENTIVE SERVICES

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 expands Medicare coverage to include the following new preventive services as of January 1, 2005:

- Initial Preventive Physical Examination (IPPE) - the "Welcome to Medicare" Physical Examination
- Cardiovascular Screening Blood Tests
- Diabetes Screening Tests

This document includes a section on each of Medicare’s comprehensive array of preventive benefits and includes useful provider and beneficiary resources:

- Initial Preventive Physical Examination (IPPE)- the "Welcome to Medicare" Physical Examination

- Cardiovascular Screening Blood Tests
- Diabetes Screening Tests, Supplies, Self-Management Training, and Other Services
- Mammography Screening
- Screening Pap Tests
- Pelvic Screening Examination
- Colorectal Cancer Screening
- Prostate Cancer Screening
- Influenza, Pneumococcal, and Hepatitis B Vaccinations
- Bone Mass Measurements
- Glaucoma Screening
- Glossary of Commonly Used Terms
- CMS and Medicare Websites
- Preventive Websites
- Preventive Benefits Chart

❖ THE INFORMATION IN THIS GUIDE

This professional resource has been developed by CMS to meet the need of the provider community for updated information on Medicare preventive services and screenings. This Guide contains a variety of information to help providers understand Medicare's coverage and requirements regarding preventive services. It also provides information about filing claims and educating beneficiaries about Medicare benefits for which they may be eligible. This information may be useful for physicians, non physician practitioners, and front office and billing staff. For each preventive service, this Guide provides the following information:

- Detailed Service Explanations
- Coverage Guidelines
- Frequency Parameters
- Coding and Diagnosis Information
- Billing Requirements
- Reimbursement Information
- Reasons for Claim Denial
- Written Advance Beneficiary Notice (ABN) Requirements

Since each service is covered comprehensively, some information may be repeated in subsequent sections. Boxes containing small amounts of text provide explanations and web links for further information.

INITIAL PREVENTIVE PHYSICAL EXAMINATION
"WELCOME TO MEDICARE" PHYSICAL EXAMINATION

❖ OVERVIEW

The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 expanded Medicare's coverage of preventive services. Central to the Centers for Medicare & Medicaid Services' (CMS') initiative to move Medicare toward a more prevention-oriented program is the new initial preventive physical examination (IPPE) also referred to as the "Welcome to Medicare" Physical Examination. All beneficiaries enrolled in Medicare Part B with effective dates that begin on or after January 1, 2005 will be covered for the IPPE benefit. This one-time benefit must be received by the beneficiary within the first six months of Medicare Part B coverage.

The goal of the IPPE, which also includes an electrocardiogram (EKG) are health promotion and disease detection and includes education, counseling, and referral to screening and preventive services also covered under Medicare Part B.

New Benefit - The Initial Preventive Physical Examination

The IPPE consist of the following seven components:

1. A review of an individual's medical and social history with attention to modifiable risk factors
2. A review of an individual's potential (risk factors) for depression
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, and visual acuity screen
5. Performance of an electrocardiogram (EKG) and interpretation of the EKG
6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements
7. Education, counseling, and referral (including a brief written plan such as a checklist for obtaining the appropriate screening and/or other Medicare Part B preventive services)

Each of these elements is further defined below.

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 health care provider to identify risk factors that may be associated with various diseases and to detect diseases early when outcomes are best. The health care 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...

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 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.

2. **Review of the beneficiary's potential (risk factors) for depression.**
   This includes current or past experiences with depression or other mood disorders, based on the use of 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.

3. **Review of the beneficiary's functional ability and level of safety.**
   This is based on the use of appropriate screening questions or screening questionnaire. 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

4. **An examination.**
   This includes measurement of the beneficiary's height, weight, blood pressure, 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.

5. **Performance and interpretation of an EKG.**
   As required by statute, the IPPE always includes a screening EKG. If the primary physician/qualified non physician practitioner does not perform the EKG during the IPPE visit, the beneficiary should be referred to another physician or entity to perform and/or interpret the EKG. Both the IPPE and the EKG must be performed and the EKG interpreted before either is billed. The primary physician or qualified non physician practitioner must document the results of the screening EKG in the beneficiary's medical record to include performance and interpretation.

Note: The referring physician/qualified non physician practitioner should ensure that the performing provider bills the appropriate G code, not a CPT code in the 93000 series. Both components of the IPPE (the examination and the screening EKG) must be performed before the claims can be submitted by the physician, qualified non physician practitioner and/or entity.

6. **Education, counseling, and referral.**
   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 elements. Examples:

   - Counseling on diet if overweight
   - Referral to a cardiologist for abnormal EKG
   - Education on prevention

7. **Education, counseling, and referral for other preventive services**.
   Education, counseling, and referral, (to include a brief written plan provided to the beneficiary, such as a checklist for obtaining the appropriate screening and/or other Medicare Part B preventive services) as listed below:

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

   Each of these preventive services and screenings are discussed in detail in this guide.

❖ COVERAGE INFORMATION

Medicare provides coverage of the IPPE for all newly enrolled beneficiaries who receive the IPPE within the first six months after the effective date of their Medicare Part B coverage, but only for those beneficiaries whose first Part B coverage period begins on or after January 1, 2005. This is a **one-time** benefit per Medicare Part B enrollee.

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

Coverage of the IPPE visit is provided as a Medicare Part B benefit. The coinsurance or copayment applies after the yearly Medicare Part B deductible has been met. No deductible applies for an IPPE provided in a Federally Qualified Health Center (FQHCs).

Who May Perform the IPPE?

Physician
Physician means 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.

❖ DOCUMENTATION

The physician or qualified non physician practitioner must document that all seven required components of the IPPE were provided or provided and referred (e.g., checklist).

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.

The physician and/or qualified non physician practitioner should use the appropriate screening tools normally used in a routine physician's practice. The 1995 and 1997 E/M documentation guidelines (www.cms.hhs.gov/medlearn/emdoc.asp) should be followed for recording the appropriate clinical information in the beneficiary's medical record.

All referrals and a written medical plan must be included in this documentation.

❖ CODING AND DIAGNOSIS INFORMATION

Procedure Codes and Descriptors

Use the following Healthcare Common Procedure Coding System (HCPCS) codes to bill for the IPPE and EKG services:

Table 1 – HCPCS Codes for the IPPE

HCPCS Code	Code Descriptor
G0344	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare Part enrollment
G0366	Electrocardiogram; routine ECG with at least 12 leads; with interpretation and report, performed as a component of the initial preventive physical examination
G0367	Tracing only; without interpretation and report, performed as a component of the initial preventive physical examination
G0368	Interpretation and report only, performed as a component of the initial preventive physical examination

Note: A physician or qualified non physician practitioner performing the complete IPPE would report both HCPCS codes G0344 and G0366. The HCPCS codes for the IPPE do not include other preventive services that are currently paid separately under Medicare Part B screening benefits. When these other preventive services are performed, they must be identified using the appropriate existing codes. The HCPCS/CPT codes for other preventive services will be provided later in this Guide.

❖ DIAGNOSIS REQUIREMENTS

Although a diagnosis code must be reported on the claim, there are no specific ICD-9-CM diagnosis codes that are required for the IPPE and corresponding screening EKG. Providers should choose an appropriate ICD-9-CM diagnosis code. Contact your local carrier for further guidance.

❖ BILLING REQUIREMENTS

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS G code (as listed in Table 1) for the IPPE and EKG must be reported on a CMS-1500 (or the HIPAA 837 Professional electronic claim format). The type of service (TOS) for each of the new codes follows:

G0344 TOS = 1
G0366 TOS = 5
G0367 TOS = 5
G0368 TOS = 5

Physicians or qualified non physician practitioners will be reimbursed for only **one** IPPE performed no later than six months after the date the beneficiary's first coverage begins under Medicare Part B. The coverage effective date must begin on or after January 1, 2005.

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

If the EKG portion of the IPPE is not performed by the primary physician or qualified non physician practitioner during 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 for the screening EKG, and **not** a CPT code in the 93000 series. **Both the IPPE and the EKG should be billed in order for the beneficiary to receive the complete IPPE service.**

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 performed may be billed in addition to G0344 and the appropriate EKG HCPCS G code.

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

Claims must be submitted on a CMS-1450 (or the HIPAA 837 Institutional electronic claim format. The appropriate HCPCS G code (Table 1) for the IPPE benefit/screening EKG service must be submitted. RHCs and FQHCs should follow normal billing procedures for RHC/FQHC services.

When a physician or qualified non physician practitioner provides a separately identifiable medically necessary E/M service in addition to the IPPE, CPT code (s) 99201 – 99215 may be used depending on the clinical appropriateness of the encounter. The E/M code should be reported with modifier – 25

Types of Bills for FIs

The FI will reimburse for the IPPE and EKG only when the services are submitted on one of the following type of bills (TOB)

Table 2 – Facility Type and Type of Bill (TOB)

Facility Type	TOB
Hospital Outpatient	12X and 13X
Skilled Nursing Facility	22X
Rural Health Clinic (RHC) (independent and provider-based)	71X
Federally Qualified Health Center (FQHC) (freestanding and provider-based)	73X
Critical Access Hospital (CAH)	85X

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. Also, CMS is eliminating the special HCPCS coding for independent and hospital-based FQHCs billed on TOB 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 0900/0910.

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

Table 3 – Facility Type and Type of Bill (TOB) for RHCs and FQHCs

Facility Type	TOB	Basis of Payment
Rural Health Clinic (RHC) (independent and provider-based)	71X	All-inclusive Rate *(for professional services)*
Federally Qualified Health Center (FQHC) (freestanding and provider-based)	73X	

- 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 constitutes a single visit.
- The technical component of the EKG performed at an independent RHC/FQHC is billed to the carrier using the practitioner ID and billing instructions.
- The technical component of the EKG performed at a provider-based RHC/FQHC is billed on the applicable TOB (Table 3) and submitted to the FI using the base provider number and billing instructions.
- RHCs and FQHCs use revenue code 052X.

❖ REIMBURSEMENT INFORMATION

General Information

The Medicare Part B deductible and coinsurance or copayment applies. No deductible applies for an IPPE provided in a Federally Qualified Health Center (FQHC).

Hospital Outpatient Department: Ambulatory Payment Classification (APC) Group
G0344 will be assigned to APC 0601
G0367 will be assigned to APC 0099
Under 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.

Additional information about MPFS can be found at: www.cms.hhs.gov/physicians/pfs/ on the Web.

Reimbursement of Claims by Carriers

Reimbursement for the IPPE is based on the Medicare Physician Fee Schedule (MPFS).

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for the IPPE is dependent upon the type of facility. The following table lists the type of payment that facilities receive for the IPPE:

Table 4 – 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 *(Paid at 101% of their reasonable cost)*
Skilled Nursing Facility	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.*

❖ REASONS FOR CLAIM DENIAL

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 six months of Medicare Part B coverage

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

INITIAL PREVENTIVE PHYSICAL EXAMINATION
THE "WELCOME TO MEDICARE" PHYSICAL EXAMINATION

Resource Materials

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 at www.cms.hhs.gov/physicians.

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule at www.cms.hhs.gov/providers.

Medicare Learning Network

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare providers. For additional information visit the Medicare Learning Network's Medlearn web page at www.cms.hhs.gov/medlearn.

Beneficiary Notices Initiative Website www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information www.cms.hhs.gov/contacts/incardir.asp

Documentation Guidelines – Evaluation Management Services
www.cms.hhs.gov/medlearn/emdoc.asp

National Correct Coding Initiative Edits Website at www.cms.hhs.gov/physicians/cciedits

CMS Legislative Summary of H.R. 1, Medicare Modernization Act of 2003 (MMA), Subtitle B, Section 611: Coverage of an Initial Preventive Physical Examination

www.cms.hhs.gov/mmu/HR1/PL108-173summary.asp#tVIsubtitleB

Final Rule, CMS-1429-FC, 42 C.F.R. Parts 40, 405, 410, 411, 414, 418, 424, 484, and 486: Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

www.cms.hhs.gov/regulations/pfs/2005/1429fc/master_background_1429-fc.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 at www.wpc-edi.com/Codes/Codes.asp

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Beneficiary-related resources can be found in Appendix C of this Guide.

CARDIOVASCULAR SCREENING BLOOD TESTS

❖ OVERVIEW

From 1979 to 2001, cardiovascular disease was the primary diagnosis for more Americans discharged from short-stay hospital visits than any other disease category. In 2001 alone, there were over 71 million physician visits, nearly 6 million hospital outpatient visits, and 4 million emergency room visits due to cardiovascular disease. In 2001, more than 6 million Americans were admitted to the hospital with a diagnosis of cardiovascular disease, of which 64.5% were 65 or older.[1] Heart disease is the number killer of American women. One in three women dies of heart disease.[2] But heart disease can also lead to disability and a significantly decreased quality of life. Unfortunately, most women don't know this. Women often fail to make the connection between risk factors, such as high blood pressure and high cholesterol, and their own chance of developing heart disease.

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. The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 established Medicare coverage of cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk.

New Benefit - Cardiovascular Screening Blood Tests

Effective with services performed on or after January 1, 2005, Medicare provides 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 will 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.

The cardiovascular screening blood tests covered by Medicare are:

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

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

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[1] The Centers for Medicare & Medicaid Services. January 9, 2004. *Medicare Issue of the Day: Medicare's Proposed Regulation to Implement New Preventive Services Under MMA* [online]. Baltimore, MD: The Centers for Medicare & Medicaid Services, The U.S. Department of Health and Human Services, 2004 [cited 1 October 2004]. Available from the World Wide Web: (www.cms.hhs.gov/medicarereform/issueoftheday/01092004iotd.pdf).

[2] The National Heart, Lung, and Blood Institute. *What is the Heart Truth?* [online]. Bethesda, MD: The National Heart, Lung, and Blood Institute, The National Institutes of Health, The U.S. Department of Health and Human Services, 2004 [cited 28 January 2005]. Available from the World Wide Web: (www.nhlbi.nih.gov/health/hearttruth/whatis/index.htm).

Risk Factors

The coverage of cardiovascular screening blood tests presents a new 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 more at risk include:

- 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 screening blood tests must be ordered by the physician or qualified non physician practitioner treating the beneficiary for the purpose of early detection of cardiovascular disease. The beneficiary must have no apparent signs or symptoms of cardiovascular disease.

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

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.

Who are Qualified Physicians and Non Physician Practitioners?

Physician
Physician means 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.

❖ DOCUMENTATION

The documentation must show that the screening tests were ordered by a physician or non physician practitioner treating an asymptomatic beneficiary for the purpose of early detection of cardiovascular disease. The beneficiary had the test performed after a 12-hour fast. The appropriate supporting procedure and diagnosis codes should be documented.

❖ CODING AND DIAGNOSIS INFORMATION

Procedure Codes and Descriptors

Use the following Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes to bill for the cardiovascular screening blood tests:

Table 1 – HCPCS/CPT Codes for Cardiovascular Screening Blood Tests

HCPCS/CPT Code	Code Descriptor
80061	Lipid Panel This panel must include: 82465, 83718, and 84478
82465	Cholesterol, serum or whole blood, total
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

One or more of the following ICD-9-CM ("V") diagnosis code(s) must be reported for cardiovascular screening blood tests:

Table 2 – Diagnosis Codes for Cardiovascular Screening Blood Tests

ICD-9-CM Diagnosis Code	Description
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 to Carriers

When submitting claims to Carriers, the appropriate HCPCS/CPT procedure code (Table 1) and the appropriate diagnosis code (Table 2) must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS codes (Table 1) and the appropriate diagnosis code (Table 2) must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills for FIs

The FI will reimburse for the cardiovascular screening blood tests when submitted on the following type of bills (TOB):

Table 3 – Facility Type and Type of Bills (TOB) for the Cardiovascular Screening Blood Tests

Facility Type	TOB
Hospital	12X, 13X, 14X
Skilled Nursing Facility (SNF)	22X, 23X
Critical Access Hospital (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

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 lab tests can be billed for by the base provider to the FI, using the base-provider's ID number. The FI will make payment to the base-provider no the RHC/FQHC. If the facility is freestanding, then the individual practitioner bills the carrier for the lab tests.

❖ REIMBURSEMENT INFORMATION

General Information

Coverage of the cardiovascular screening blood tests is provided 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

Reimbursement for the cardiovascular screening blood tests is based on the Medicare Clinical Laboratory Fee Schedule.

Additional information about the Clinical Laboratory Fee Schedule can be found at: www.cms.hhs.gov/providers/pufdownload/clfcrst.asp on the Web.

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for the cardiovascular screening blood tests is dependent upon the type of facility. The following table 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

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

- The beneficiary received a covered Lipid Panel during the past 5 years.
- The beneficiary received the same individual cardiovascular screening blood test during the past 5 years.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

CARDIOVASCULAR SCREENING BLOOD TESTS

Resource Materials

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.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule.
www.cms.hhs.gov/providers

Medicare Learning Network

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

Beneficiary Notices Initiative Website

www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information

www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website

www.cms.hhs.gov/physicians/cciedits

CMS Legislative Summary H.R. 1, MMA, Subtitle B, Section 612: Coverage of a Cardiovascular Screening Blood Test

www.cms.hhs.gov/mmu/HR1/PL108-173summary.asp#tVIsubtitleB

Final Rule, CMS-1429-FC, 42 C.F.R. Parts 40, 405, 410, 411, 414, 418, 424, 484, and 486: Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

www.cms.hhs.gov/regulations/pfs/2005/1429fc/master_background_1429-fc.pdf

United States Preventive Services Task Force (USPSTF): Screening for Lipid Disorders in Adults

www.ahcpr.gov

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.
www.wpc-edi.com/Codes/Codes.asp

Beneficiary-related resources can be found in Appendix C of this Guide.

DIABETES SCREENING TESTS, SUPPLIES, SELF-MANAGEMENT TRAINING, AND OTHER SERVICES

❖ OVERVIEW

Diabetes is the sixth leading cause of death in the United States. 17 million Americans have diabetes, and over 200,000 individuals die each year of related complications.[3] These complications include 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. With early detection and treatment the development of severe vision loss can be reduced by 50 – 60 percent and kidney failure can be reduced by 30 – 70 percent.

Millions of people have diabetes and do not know it. However, with early detection and treatment the more likely it is that the serious health consequences of diabetes can be prevented or delayed. The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, expanded diabetic services covered by Medicare to include diabetes 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.

Risk Factors

To be eligible for the diabetes screening tests beneficiaries must have any of the following risk factors or at least 2 of the following characteristics:

[3] The Centers for Medicare & Medicaid Services. 2004. *Diabetes Brochure* [online]. Baltimore, MD: The Centers for Medicare & Medicaid Services, The U.S. Department of Health and Human Services, 2004 [cited 1 October 2004]. Available from the World Wide Web: (www.cms.hhs.gov/medlearn/diabetes_brochure.pdf).

Individuals 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/m2)
- Previous identification of an elevated impaired fasting glucose or glucose intolerance

OR

Individuals who have a risk factor consisting of at least 2 of the following characteristics:

- Overweight (a body mass index greater than 25 kg/m2 but less than 30kg/m2)
- Family history of diabetes
- Age of 65 or older
- A History of gestational diabetes mellitus, or delivery of a baby weighing greater than 9 pounds

New Benefit - Diabetes Screening Tests

Effective with services provided on or after January 1, 2005, Medicare provides coverage of diabetes screening tests for individuals in the risk groups previously listed or those diagnosed with pre-diabetes. This new benefit will allow for earlier diagnosis for Medicare beneficiaries, which will assist in treatment and management of the disease.

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:

- A fasting blood glucose test

AND

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

    OR
    - a 2-hour post-glucose challenge test alone

❖ COVERAGE INFORMATION

Effective with services performed on or after January 1, 2005, provides coverage for diabetes screening tests with the following frequency:

Beneficiaries diagnosed with pre-diabetes

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

Non-diabetic and not previously diagnosed as pre-diabetic

Medicare provides coverage for one 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 non-diabetic and not previously diagnosed as "pre-diabetes".

Coverage for diabetes screening is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayments do not apply. The beneficiary will not pay for this screening.

Who are Qualified Physicians and Non Physician Practitioners?

Physician
Physician means 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

❖ CODING AND DIAGNOSIS INFORMATION

Procedure Codes and Descriptors

The Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes used to report diabetes screening tests are:

Table 1 – HCPCS/CPT Codes for Diabetes Screening Tests

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

NOTE: Procedure codes are paid under the Clinical Laboratory Fee Schedule.

Diagnosis Requirements

The screening ("V") diagnosis code V77.1 (Special Screening for Diabetes Mellitus) must be reported.

❖ BILLING REQUIREMENTS

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate Healthcare Common Procedure Coding System (HCPCS) code (see Table 1) and the corresponding ICD-9-CM diagnosis code (s) for the service (s) provided must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at www.cms.hhs.gov/physicians/cciedits on the Web.

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate Healthcare Common Procedure Coding System (HCPCS) code (see Table 1), the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code (s) must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Type of Bills (TOB) For FIs

The applicable FI claim type of bills (TOB) and associated revenue codes for diabetes screening tests are:

Table 2 – Facility Type and Type of Bills (TOB) for Diabetes Screening Services

Facility Type	TOB
Hospital Inpatient (for Medicare Part B services)	12X
Hospital Outpatient	13X
Hospital Outpatient - Other	14X
Critical Access Hospital (CAH)	85X
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X
SNF Outpatient	23X

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 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 lab tests can be billed for by the base provider to the FI, using the base-provider's ID number. The FI will make payment to the base-provider no the RHC/FQHC. If the facility is freestanding, then the individual practitioner bills the carrier for the lab tests.

❖ REIMBURSEMENT INFORMATION

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

Critical Access Hospitals (CAHs) will be reimbursed at 101% of their reasonable cost.

Maryland hospitals will be reimbursed according to the Maryland State Cost Containment Plan.

Claims from physicians, non physician practitioners, or suppliers where assignment is not accepted are subject to Medicare's limiting charge.

Additional information about the Clinical Laboratory Fee Schedule can be found at: www.cms.hhs.gov/providers/pufdownload/clfcrst.asp on the Web.

Reimbursement of Claims by Carriers

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

Reimbursement of Claims by Fiscal Intermediaries (FIs)

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

❖ REASONS FOR CLAIM DENIAL

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

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

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

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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

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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.

❖ DIABETES SUPPLIES

In addition to the new diabetes screening tests, Medicare also 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 supplies
- 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 diabetics based on medical necessity.

Coverage Information

Coverage for diabetes-related Durable Medical Equipment (DME) is provided 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.

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.

For information regarding Medicare's medical necessity requirements and claim filing information, please contact the local DMERC. Please visit www.cms.hhs.gov/suppliers/dmepos/default.asp for the name, address, and telephone number of the local DMERC.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The Health Care Common Procedure Coding System (HCPCS) codes used to report blood glucose self-testing equipment and supplies are:

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

HCPCS Code	HCPCS Code Descriptor
A4253	50 test strips for a blood glucose monitor
A4259	100 lancets for a blood glucose monitor
E0607	Home blood glucose monitor

For Medicare coverage of 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
- How often the beneficiary should test the level of blood sugar

Insulin-Dependent

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

- 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:

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

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 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

Coverage for depth-inlay shoes, custom-molded shoes, and shoe inserts for beneficiaries with diabetes is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the 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
  - 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

The Health Care Common Procedure Coding System (HCPCS) codes used to report therapeutic shoes are:

Table 4 – HCPCS Codes for Therapeutic Shoes

HCPCS Code	HCPCS Code Descriptor
K0628	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 ¼ inch material of Shore A 35 durometer or 3/16 inch material of Shore A 40 (or higher), prefabricated, each
K0629	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 (criteria listed in following table). Insulin pumps are available through a prescription. Beneficiaries must meet either of the following criteria to receive coverage for an external infusion pump for insulin and related drugs and supplies:

Criteria A	Criteria B
The patient 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 dose 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 (HbAlc) > 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 • 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.

Diabetes needs to be documented by a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. Continued coverage of the insulin pump would require that the beneficiary has been seen and evaluated by the treating physician at least every 3 months. The pump must be ordered by, and follow-up care of the beneficiary must be managed by, a physician who manages multiple patients with Continuous Subcutaneous Insulin Infusion Pumps (CSII) and who works closely with a team including nurses, diabetes educators, and dieticians who are knowledgeable in the use of CSII.

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

The Healthcare Common Procedure Coding System (HCPCS) codes used to report insulin pumps and supplies are:

Table 5 – HCPCS Codes for Insulin Pumps and Supplies

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

Billing Requirements

Billing and Coding Requirements Specific to Durable Medical Equipment Regional Carriers (DMERCs)

For information regarding Medicare's medical necessity requirements and claim filing information, please contact the local DMERC. Please visit www.cms.hhs.gov/suppliers/dmepos/default.asp for the name, address, and telephone number of the local DMERC.

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

Reimbursement Information

Reimbursement of diabetes supplies is made by the four DMERCs based on a national Fee Schedule. Medicare Part B deductible and coinsurance do apply. Medicare allows 80% of the approved Fee Schedule.

Claims from physicians, non physician practitioners, or suppliers where assignment was not taken are subject to Medicare's limiting charge.

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.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

Written Advance Beneficiary Notice (ABN) Requirements

An Advance Beneficiary Notice (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.

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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.

❖ DIABETES SELF-MANAGEMENT TRAINING (DSMT) SERVICES

Medicare provides coverage for 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. DSMT services are intended to educate beneficiaries in the successful self-management of diabetes. A qualified DSMT program includes:

- Instructions in self-monitoring of blood glucose
- Education about diet and exercise
- An insulin treatment plan developed specifically for insulin dependent patients
- 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
- 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
- Use of health care systems and community resources

Coverage Information

Medicare provides coverage of DSMT services only if the physician managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care. This plan of care must describe the content, number of sessions, frequency, and duration of the training, and must be written by the physician (or qualified non physician practitioner). The plan of care must also include a statement by the physician (or non physician practitioner) and the signature of the physician (or qualified non physician practitioner) denoting any changes to the plan of care, if applicable.

The plan of care must include the following:

- 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 program curriculum or specific areas such as nutrition or insulin training)
- 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. For coverage by Medicare, DSMT services must:

- Be accredited as a DSMT program by the American Diabetes Association (ADA) or Indian Health Services (IHS)
- Provide services to eligible Medicare beneficiaries that are diagnosed with diabetes

- Submit an accreditation certificate from the ADA, IHS, or another Centers for Medicare & Medicaid Services (CMS)-recognized program to the local Medicare Contractor's provider enrollment department

Medicare will pay for 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 increments of no less than 30 minutes spread over the 12-month period (or a portion of that period)
- With the exception of 1 hour of individual training, training is usually furnished in a group setting with other patients who need not all be Medicare beneficiaries
- The hour of individual training may be used for any part of the training including insulin training

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

- No group session is available within 2 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 non physician practitioner, that will hinder effective participation in a group training session
- The physician orders additional insulin training

The need for individual training must be identified by the physician or non physician practitioner in the referral.

NOTE: If individual training has been provided to a Medicare beneficiary and subsequently the Carrier or FI determines that training should have been provided in a group setting, instead of denying the service as billed, the appropriate actions are down-coding the reimbursement from individual-level to group-level and provider education.

After receiving the initial training, Medicare pays for follow-up training that meets the following conditions:

- Consists of no more than 2 hours individual or group training for a beneficiary each year

- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries

- Is furnished any time in a calendar year following a year in which the beneficiary completes the initial training (e.g., beneficiary completes initial training in November 2004; therefore the beneficiary is entitled to 2 hours of follow-up training beginning in January 2005)

- Is furnished in increments of no less than one-half hour

- The physician (or qualified non physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary has diabetes

Coverage for DSMT services is provided as a Medicare Part B benefit. Deductible and coinsurance do apply. The Medicare Part B deductible and coinsurance or copayments applies. Claims from physicians, non physician practitioners, or suppliers where assignment was not taken are subject to Medicare's limiting charge.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The HCPCS/CPT codes used to report DSMT services are:

Table 6 – HCPCS Codes for DSMT Services

HCPCS/CPT Codes	HCPCS/CPT Code Descriptors
G0108	Diabetes outpatient DSMT services, individual session, per 30 minutes
G0109	Diabetes screening tests, and outpatient DSMT services, group session (2 or more), per 30 minutes

Services for DSMT must be billed with the appropriate HCPCS/CPT code in 30 minute increments. Providers billing FIs must include the revenue code 942 along with the appropriate HCPCS/CPT code.

Billing Requirements

General

CMS is designating as certified all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians, and DME suppliers. All providers and suppliers 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.

Providers and suppliers are eligible to bill for DSMT services if they are associated with an accredited DSMT program. Billing for DSMT services cannot be submitted as incident to services. However, a physician advisor for a DSMT program is eligible to bill for the DSMT service for that program.

Also, the following conditions apply:

- A cover letter and Unique Provider Identification Number (UPIN) must be included with the accreditation certificate
- The 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.

CMS will not reimburse services on a fee-for-service basis rendered to any beneficiary who is:

- An inpatient in a hospital or SNF
- In hospice care
- A resident in a nursing home
- An outpatient in a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC)

DME suppliers are reimbursed through local Carriers.

Claims from physicians, non physician practitioners, or suppliers where assignment is not accepted are subject to Medicare's limiting charge.

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS code (see Table 6) and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS code (see Table 6), the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills For FIs

As required by CMS, there are eight specific bill types that are applicable for DSMT services. The applicable FI claim bill types for DSMT services are:

Table 7 – Facility Type, Type of Bill, and Revenue Code for DSMT

Facility Type	Type of Bill	Revenue Codes
Hospital Inpatient (for Medicare Part B services)	12X	0942
Hospital Outpatient	13X	
Home Health Agency	34X	
Renal Dialysis Facility (RDF)	72X	
ORF (Outpatient Rehabilitation Facility)	74X	
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	

Facility Type	Type of Bill	Revenue Codes
Hospital Outpatient Surgery [subject to Ambulatory Surgical Center (ASC) Payment Limits]	83X	
Critical Access Hospital (CAH)	85X	

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

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 G0108 and G0109.
- The nutrition portion of the DSMT program must be billed using 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.
- 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 cost of such services can be bundled into their clinic/center payment rates. However, RHCs and FQHCs and must meet all coverage requirements.
- Medicare pays for 10 hours of initial DSMT in a continuous 12-month period. Two hours of follow-up DSMT may be covered in subsequent years.

Reimbursement Information

Reimbursement for outpatient DSMT is based on rates established under the Medicare Physician Fee Schedule (MPFS).

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at www.cms.hhs.gov/physicians/cciedits on the Web.

- Payment may only be made to any provider that bills Medicare for other individual Medicare services.

Additional information about MPFS can be found at: www.cms.hhs.gov/physicians/pfs/ on the Web.

- Payment may be made only for training sessions actually attended by the beneficiary and documented on attendance sheets.
- Other conditions for fee-for-service payment. The beneficiary must meet the following conditions 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
- The beneficiary is not receiving services as an inpatient in a hospital, SNF, hospice, or nursing home
- The beneficiary is not receiving services as an outpatient in a RHC or FQHC

While separate payment is not made for this service to RHCs or FQHCs, the service is covered but is considered included in the encounter rate. All DSMT programs must be accredited as meeting quality standards by a CMS-approved national accreditation organization.

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 did not order the training.
- The individual furnishing the DSMT is not accredited by Medicare.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

Written Advance Beneficiary Notice (ABN) Requirements

An Advance Beneficiary Notice (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.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

❖ MEDICAL NUTRITION THERAPY (MNT)

Medicare also pays for Medical Nutrition Therapy for beneficiaries diagnosed with diabetes or a renal disease. For the purpose of disease management, covered services include:

- An initial nutrition and lifestyle assessment
- Nutrition counseling
- Information regarding managing lifestyle factors that affect diet
- Follow-up sessions to monitor progress

This covered benefit provides 3 hours of one-on-one counseling services for the first year and 2 hours of coverage for subsequent years. The dietician/nutritionist may choose how many units are provided per day. Based on medical necessity, additional hours may be covered if the treating physician orders additional hours of Medical Nutrition Therapy based on a change in medical condition, diagnosis, or treatment regimen.

Coverage Information

Medicare provides coverage of Medical Nutrition Therapy services based on a required physician referral; non physician practitioners cannot make referrals for this service. Medical Nutritional Therapy services must be provided by a qualified dietitian, licensed registered dietitian, a licensed nutritionist that meets the registered dietitian requirement, or a "grandfathered" nutritionist that was licensed as of December 12, 2000.

Coverage for diabetes-related Medical Nutrition Therapy is provided as a Medicare Part B benefit. The beneficiary will pay 20% (as the coinsurance or copayment) of the Medicare-approved amount after meeting the yearly Medicare Part B deductible.

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

Coding and Diagnosis Information

Procedure Codes and Descriptors

The HCPCS/CPT codes used to report Medical Nutrition Therapy services are:

Table 8 – HCPCS/CPT Codes for Medical Nutrition Therapy Services

HCPCS/CPT Codes	HCPCS/CPT Code Descriptors
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.)
97803	Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Group (2 or more individual(s), each 30 minutes
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), individual, group (2 or more individuals), each 30 minutes

Table 9 – Instructions for Use of the Medical Nutrition Therapy Codes

HCPCS/CPT Codes	Instructions for Use
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: The above codes can only be paid if submitted by a registered dietitian or nutrition professional who meets the specified requirements under Medicare. These services cannot be paid "incident to" physician services. The payments can be reassigned to the employer of a qualifying dietician or nutrition professional.

Diagnosis Requirements

Medical Nutrition Therapy services are available for beneficiaries with diabetes or renal disease when referral is made by a physician. For diagnosis information for diabetes mellitus, refer to Diagnosis Requirements for Diabetes Screening Tests. For the purpose of this benefit, renal disease means chronic renal insufficiency and the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 6 months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [Glomerular Filtration Rate (GFR) 13-15 ml/min/1.73m2].

Coding Tips

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.

Entities which may participate as RHCs or FQHCs may also choose to become accredited providers of Medical Nutrition Therapy services. The cost of such services can be bundled into their clinic/center payment rates. However, RHCs and FQHCs must meet all coverage requirements.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers

When submitting claims to Carriers, the appropriate HCPCS code (see Table 8) and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS code (see Table 8), the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills For FIs

As required by CMS, there are two specific bill types that are applicable for MNT. The applicable FI claim bill types and associated revenue codes for MNT are:

Table 10 – Facility Type, Type of Bill, and Revenue Codes for MNT

Facility Type	Type of Bill	Revenue Codes
Hospital Outpatient	13X	0942
Critical Access Hospital (CAH)	85X	

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 furnishing the MNT is not accredited by Medicare.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

Written Advance Beneficiary Notice (ABN) Requirements

An Advance Beneficiary Notice (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.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

❖ OTHER DIABETES SERVICES

In addition to DSMT and Medical Nutrition Therapy services, Medicare provides coverage of the following diabetes services:

- Foot Care
- Hemoglobin A1c tests
- Glaucoma screening
- Influenza and Pneumococcal Polysaccharide Vaccine (PPV)
- Routine costs, including immunosuppressive drugs, cell transplantation, and related items and services for pancreatic islet cell transplant clinical trials

NOTE: Details regarding glaucoma screening, and influenza and PPV vaccination are described in this Guide. For specific information regarding other diabetes services, refer to relevant CMS documentation.

Diabetic Supplies and Services Not Covered by Medicare

The Original Medicare Plan does not pay for all diabetes supplies and equipment for a beneficiary. The following are excluded from coverage under Medicare Advantage:

- Prescription drugs
- 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)
- Routine or yearly physical exams
- Weight loss programs
- Injection devices (jet injectors)

Note: Coverage of insulin and associated diabetes supplies, including syringes, will begin in 2006.

DIABETES SCREENING TESTS, SUPPLIES, SELF-MANAGEMENT TRAINING, AND OTHER SERVICES

Resource Materials

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.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule.
www.cms.hhs.gov/providers

Medicare Learning Network

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

Beneficiary Notices Initiative Website

www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information

www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website

www.cms.hhs.gov/physicians/cciedits

America Diabetes Association, Homepage For Health Professionals and Scientists

www.diabetes.org/for-health-professionals-and-scientists/professionals.jsp

Final Rule, CMS-1429-FC, 42 C.F.R. Parts 40, 405, 410, 411, 414, 418, 424, 484, and 486: Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

www.cms.hhs.gov/regulations/pfs/2005/1429fc/master_background_1429-fc.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.
www.wpc-edi.com/Codes/Codes.asp

Beneficiary-related resources can be found in Appendix C of this Guide.

MAMMOGRAPHY SCREENING

❖ 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 U.S. 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.[4]

In 2003, there were 211,300 invasive and 55,700 in situ projected cases of breast cancer.[5] Although breast cancer incidence (all ages) is approximately 20% 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 mammography screening benefit offered by Medicare can provide early detection and 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 (BBA) of 1997 revised the statutory frequency parameters and age limitations Medicare uses to cover screening mammograms. The Benefits Improvement and Protection Act (BIPA) of 2000 established coverage and payment of Computer-Aided Detection (CAD) in conjunction with the performance of a mammogram.

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

Screening Mammography

Screening mammographies are radiologic procedures for the early detection of breast cancer and include a physician's interpretation of the results. A screening mammography is performed on an asymptomatic female to detect the presence of breast cancer at an early stage. The breast is X-rayed from top to bottom and from side to side. The patient typically has not manifested any clinical signs, symptoms, or physical findings of breast cancer. The procedure is performed to detect the presence of a breast abnormality in its incipient stage and to serve as a baseline to which future screening or diagnostic mammograms may be compared.

[4]The National Cancer Institute. June 10, 2003. *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, 2003 [cited 30 September 2004]. Available from the World Wide Web: (www.cancer.gov/cancertopics/pdq/prevention/breast/Patient/page2).

[5]The American Cancer Society, Inc. 2003. *Breast Cancer Facts & Figures 2003-2004* [online]. Atlanta, GA: The American Cancer Society, Inc., 2003 [cited 30 September 2004]. Available from the World Wide Web: (www.cancer.org/downloads/STT/CAFF2003BrFPWSecured.pdf).

Diagnostic Mammography

Diagnostic mammographies are generally performed on an individual with:

- Clinical signs, symptoms, or physical findings suggestive of breast cancer.
- An abnormal or questionable screening mammogram.
- A personal history of breast cancer.
- A personal history of biopsy-proven benign breast disease.

Diagnostic mammography is also called "problem-solving mammography" or "consultative mammography". A diagnostic mammogram is performed because there is a reasonable suspicion that an abnormality may exist in the breast. The diagnostic mammogram may confirm or deny the presence of an abnormality and, if confirmed, may assist in determining the nature of the problem.

A diagnostic mammogram focuses in on a particular lump or area of abnormal tissue. In addition, a diagnostic mammogram involves further consultation and testing to clarify the results of a questionable baseline or screening mammogram.

However, diagnostic mammographies are Medicare covered diagnostic tests under the following conditions:

- A woman has distinct signs and symptoms for which a mammogram is indicated
- A woman has a history of breast cancer
- A woman is asymptomatic, but based on her 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 if she:

- Has a personal history of breast cancer.
- Has a family history of breast cancer.
- Had her first baby after age 30.
- Has never had a baby.

❖ COVERAGE INFORMATION

Medicare provides coverage of a breast cancer screening mammogram annually (i.e., at least 11 months have passed following the month in which the last Medicare-screening mammography 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 mammography services applies as follows:

Age Group	Coverage
Under age 35	No payment allowed
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)

A doctor's prescription or referral is not necessary for a screening mammogram or diagnostic mammography procedures. Payment of mammography services is determined by a woman's age and statutory frequency parameters

Mammography services must be provided in a certified radiological facility and the results must be interpreted by a qualified physician who is directly associated with the facility at which the mammogram was taken.

Coverage for breast cancer screening mammography is provided as a Medicare Part B benefit. The coinsurance or copayment applies. There is no Medicare Part B deductible for this benefit.

Medicare also covers digital technologies for mammogram screenings. The coinsurance or copayment applies. There is no Medicare Part Be deductible for this benefit. However, in a hospital outpatient setting the coinsurance or copayment applies.

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

NOTE: Screening and diagnostic mammograms must be furnished at Food and Drug Administration (FDA) certified facilities for coverage.

❖ CODING AND DIAGNOSIS INFORMATION

Procedure Codes and Descriptors

The Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) and type of service codes (TOS) used to report mammography services are:

Table 1 – HCPCS/CPT Codes for Mammography Services

HCPCS/CPT Code	TOS	Code Descriptor
76082	4	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). **Effective January 1, 2004.**
76083	1	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). **Effective January 1, 2004.**
76085	1	Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation screening mammography (list separately in addition to code for primary procedure). Use with CPT code 76092 **Code 76085 was effective 1-1-2002 for all claims submitted to a carrier or an FI, except hospital outpatient prospective payment (OPPS) claims, which are billed to the FI. For OPPS claims billed to the FI, this code is effective 4-1-2002. Deleted as of December 31, 2003.**
76090	1	Diagnostic mammography, unilateral.
76091	1	Diagnostic mammogram, bilateral.
76092	1,B,C	Screening mammography, bilateral (two view film study of each breast).

HCPCS/CPT Code	TOS	Code Descriptor
G0202	1	Screening mammography, producing direct digital image, bilateral, all views. **Code Effective 4-1-2001.**
G023		Screening mammography film processed to produce digital images analyzed for potential abnormalities, bilateral all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
G0204	4	Diagnostic mammography, direct digital image, bilateral, all views; **Code Effective 4-1-2001.**
G0205		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
G0206	1	Diagnostic mammography, producing direct digital image, unilateral, all views; **Code Effective 4-1-2001.**
G0207		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
G0236		Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure). Use with CPT Codes 76090 or 76091. **Code G0236 was effective 1-1-2002 for all claims submitted to a carrier or an FI except hospital OPPS claims, which are billed to the FI. For OPPS claims billed to the FI, the code is effective 4-1-2002. Deleted as of December 31, 2003.**

Diagnosis Requirements

Effective January 1, 1998, the Balanced Budget Act (BBA) of 1997 eliminated payment based on high risk indicators. Effective January 1, 1998 providers only reported diagnosis code V76.12 on screening mammography claims.

Effective July 1, 2005, (see CR 3562) to assure proper coding, one of the following ICD-9-M diagnosis codes should be reported on screening mammography claims as appropriate:

V76.11 – “Special screening for malignant neoplasm, screening mammogram for high-risk patient” or;

V76.12 – “Special screening for malignant neoplasm, other screening mammography.”

Diagnosis codes for a diagnostic mammogram 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 mammography is allowed to order and interpret additional diagnostic films based upon 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** – services rendered outside the scope of the physician's interpretation of the results of an examination.
- **Professional Component** – 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 setting except for Critical Access Hospitals (CAHs) electing the optional payment method.

When submitting a claim for a screening mammogram and a diagnostic mammogram for the same beneficiary on the same day, attach modifier "GG" to the diagnostic mammogram (CPT codes 76090 and 76091 or HCPCS codes G0204 or G0206). Medicare requires 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.

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.

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.

The Computer-Aided Detection (CAD) mammography codes 76082 and 76083 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 (see Table 1).

FDA certified mammography centers may have a certification number for film mammography and/or digital mammography. The appropriate certification number must be submitted with the claim depending on the type of mammogram furnished.

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS/CPT code (see Table 1) and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS/CPT code (see Table 1), the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills For FIs

As required by CMS, there are six specific bill types that are applicable for mammography services. The applicable FI claim bill types and associated revenue codes for mammography services are:

Table 2 – Facility Type, Type of Bill, and Revenue Codes for the "*Professional Component*" of Mammography Services

Facility Type		Type of Bill	Revenue Codes
Hospital Outpatient - Other		14X	0403
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	For a screening mammography	22X	0403
	For a diagnostic mammography		0401
Rural Health Clinic (RHC) (independent and provider-based) (Provider Ranges 3400-3499, 3975-3999 and 8500-8899)	For a screening mammography	71X	0403 (see following additional instructions)
	For a diagnostic mammography		0401 (see following additional instructions)
Federally Qualified Health Center (FQHC) (freestanding and provider-based)	For a screening mammography	73X	0403 (see following additional instructions)
	For a diagnostic mammography		0401 (see following additional instructions)
Critical Access Hospital (CAH)	Those that elect the optional method of payment for outpatient services	85X	0403 or 097X
	Those that do not elect the optional method of payment		0403

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. Also, CMS is eliminating the special HCPCS coding for independent and hospital-based FQHCs billed on TOB 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 0900/0910.

NOTE: Effective April 1, 2005, the correct TOB for hospitals billing Medicare for diagnostic and screening mammographies is 13X.

NOTE: Each FI may choose to accept other bill types for the "*technical component*" of the screening mammogram. If the provider would like to bill using a different bill type, the provider must contact the local Medicare FI 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 mammogram, the provider of that service must bill the FI under bill type 14X, 22X, 23X, or 85X, as appropriate, using the outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services).

  - The appropriate revenue code for a screening mammogram must be used from Table 2, in addition to HCPCS codes 76083 and 76092 and RHC/FQHC revenue code 0521 or 0520, respectively, to report the related visit. FIs will not make payment for revenue code 0403 unless the claim also includes visit revenue codes of 0521 or 0520, respectively.

  - The appropriate revenue code for a diagnostic mammogram must be used from Table 2, in addition to HCPCS codes 76082, 76090, and 76091, and RHC/FQHC revenue code 0521 or 0520, respectively, to report the related visit. FIs will not make payment for revenue code 0401 unless the claim also includes visit revenue codes of 0521 or 0520, respectively.

- *Professional Component* for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a screening mammogram is furnished within an RHC/FQHC by a physician or non physician, the screening mammogram is considered an RHC/FQHC service. The provider of a screening mammography service must bill the FI under bill type 71X or 73X respectively.

  - The appropriate revenue code for a screening mammogram must be used from Table 2, in addition to HCPCS codes 76083 or 76092 and RHC/FQHC revenue code 0521 or 0520, respectively, to report the related visit. FIs will not make payment for revenue code 0403 unless the claim also includes visit revenue codes of 0521 or 0520, respectively.

- The provider (RHC/FQHC) of a diagnostic mammography service must bill the FI under bill type 71X or 73X, respectively.

- The appropriate revenue code for a diagnostic mammogram must be used from Table 2, in addition to HCPCS codes 76090 or 76091 and RHC/FQHC revenue code 0521 or 0520 respectively, to report the related visit. FIs will not make payment for revenue code 0401 unless the claim also includes visit revenue codes of 0521 or 0520, respectively.

NOTE: The age of the beneficiary, the date of the last mammogram, and the presence of a high risk diagnosis indicator must also be included in the applicable fields. When submitting this service to the FI, do not include any other service(s) on the claim.

❖ REIMBURSEMENT INFORMATION

General Information

NEW - 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 Computer Add-on diagnostic (CAD) services based on the Medicare Physician Fee Schedule (MPFS). Payment will no longer be made under the Outpatient Prospective Payment System (OPPS).

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

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

Reimbursement for mammography services is issued for the *technical* and *professional* components of the mammography when furnished by separate providers. Providers furnishing both components are paid the *global* fee.

Reimbursement for CAD mammography codes 76082 and 76083 cannot be made if billed alone. They must be billed with in conjunction with the primary service codes (see Table 1).

Reimbursement of Claims by Carriers

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

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 (FIs)

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, (see Table 3).

See the National Correct Coding Initiative (CCI) edits web page for currently applicable bundled Carrier processed procedures at www.cms.hhs.gov/physicians/cciedits on the web.

See the OPPS CCI edits web page for currently applicable bundled FI processed procedures at: www.cms.hhs.gov/providers/hopps/cciedits on the Web.

A facility-based provider may bill for a mammography service either for the *technical* component only or for the *global* component. Facilities may also bill for the CAD codes. Facilities will not be paid for the *professional* component billed alone.

Table 3 – Types of Payments Received for Mammography Services Furnished by Facilities

Provider of Service	Form of Payment
CAH	Reasonable Cost Basis (See following options)
FQHC (freestanding and provider-based)	All-inclusive rate for the professional component (codes 76090 and 76091
Hospital Outpatient Department	OPPS (based on MPFS)
RHC (independent and provider-based)	All-inclusive rate for the professional component (codes 76090 and 76091
SNF	MPFS

Critical Access Hospital (CAH) Payment

Although the form of payment for CAHs is based on reasonable cost, there are two payment options available that CAHs may elect. These two payment options are an optional/all-inclusive method, or a standard method. Each method is discussed in further detail in the following sections.

CAH Payment under the Optional Method (All-Inclusive)

A CAH has the option to elect an all-inclusive method of payment for outpatient services by utilizing reasonable costs for facility services. This may be an amount equal to 115% of the allowed amount for the professional component (costs related to professional services are excluded from the cost payment).

Payment to the CAH will be the sum of the following amounts:

> [(Interim rate) x (Charge for facility services)] + (115% of the MPFS for the professional services) – (Any coinsurance collected by the CAH based on charges)

CAHs that have elected the optional method of reimbursement may bill the Carrier on Form CMS-1500 (or the HIPPA 837 Professional electronic claim format) for the global amount. CAHs electing the optional method of reimbursement bill the FI with Type of Bill 85X, revenue code 0403, and HCPCS code 76092. They also include the professional component on a separate line, repeating revenue code 0403 and HCPCS code 76092, and adding modifier "-26" to designate the professional component.

NOTE: A CAH may bill an FI globally if the CAH elected the optional method of payment for mammography services furnished on or after January 1, 2002.

CAH Payment under the Standard Method

CAHs not electing the optional method of payment for outpatient services are paid under the standard method. The MPFS is the basis for payment of screening mammograms performed by CAHs electing the standard method. Comprehensive CAH mammography payment information and tables are available in the Medicare Claims Processing Manual, Chapter 18, Section 20.3.2.3.1 at www.cms.hhs.gov/manuals on the Web.

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 www.cms.hhs.gov/manuals on the Web.

❖ REASONS FOR CLAIM DENIAL

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-certified mammography provider.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

MAMMOGRAPHY SCREENING

Resource Materials

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.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule and the OPPS.
www.cms.hhs.gov/providers

Medicare Learning Network

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

Beneficiary Notices Initiative Website

www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information

www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website

www.cms.hhs.gov/physicians/cciedits

Breast Cancer: Prevention

A guide to breast cancer prevention produced by the National Cancer Institute.
www.cancer.gov/cancertopics/pdq/prevention/breast/Patient/page2

Breast Cancer Facts & Figures 2003-2004

A comprehensive resource including many breast cancer statistics produced by the American Cancer Society.
www.cancer.org/downloads/STT/CAFF2003BrFPWSecured.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.
www.wpc-edi.com/Codes/Codes.asp

Beneficiary-related resources can be found in Appendix C of this Guide.

SCREENING PAP TESTS

❖ OVERVIEW

In 2004, an estimated 10,520 cases of invasive cervical cancer are expected to occur in the U.S., with about 3,900 women dying from this disease. Additionally, cervical cancer mortality increases with age; women ages 65 and older account for nearly 25% of all cervical cancer cases and 41% of cervical cancer deaths in the U.S. Among these women over age 65, cervical cancer mortality for African-American women is more than 2.5 times higher than it is for Caucasian women.[6]

However, incidence and mortality rates of cervical cancer are decreasing over time. This trend is largely attributed to cervical screening with the Pap smear/test. Screening Pap smears are laboratory tests consisting of a routine exfoliative cytology test (Papanicolaou test) provided for the purpose of early detection of cervical cancer. It includes a collection of the sample of 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 examination benefit offered by Medicare can help reduce 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

The high risk factors for cervical and vaginal cancer categories are:

<u>Cervical Cancer High Risk Factors</u>

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of a sexually transmitted disease (including Human papillomavirus HIV infection)
- Fewer than three negative Pap tests within the previous seven years

<u>Vaginal Cancer High Risk Factors</u>

- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

[6] The National Cancer Institute. July 13, 2004. *Cervical Cancer (PDQ): Screening* [online]. Bethesda, MD: The National Cancer Institute, The National Institutes of Health, The U.S. Department of Health and Human Services, 2004 [cited 1 October 2004]. Available from the World Wide Web: (http://www.nci.nih.gov/cancertopics/pdq/screening/cervical/HealthProfessional/page2).

❖ COVERAGE INFORMATION

Medicare provides coverage of a screening Pap test for all female beneficiaries when the test is ordered and collected by 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) under **one** of the following conditions:

Covered once every 12 months:

- 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; **and** at least 11 months have passed following the month that the last covered Pap smear was performed.

- There is evidence the woman is in one of the high risk categories (previously identified) for developing cervical or vaginal cancer, other specified personal history presenting hazards to health) **and** at least 11 months have passed following the month that the last covered screening Pap smear was performed.

Covered once every 24 months:

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

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.*

Coverage for a Pap test is provided as a Medicare Part B benefit. The coinsurance or copayment applies for the Pap test collection. There is no Medicare Part B deductible for this benefit. The beneficiary will pay nothing for the Pap laboratory test.

❖ CODING AND DIAGNOSIS INFORMATION

Procedure Codes and Descriptors

The following are Healthcare Common Procedure Coding System (HCPCS) codes for reporting 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. Medicare-covered Pap tests are reported using the following HCPCS codes:

Table 1 – HCPCS Codes for Screening Pap Tests

HCPCS Code	HCPCS Code Descriptors
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 re-screening 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 reevaluation.
P3000	Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision.

There are three HCPCS codes for reporting 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.

The following HCPCS codes are used to report the physician's interpretation of screening Pap tests:

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

HCPCS Code	HCPCS Code Descriptors
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.

The following code must be used 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	HCPCS Code Descriptor
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory.

Diagnosis Requirements

When a claim is filed for a screening Pap test, one of the screening ("V") diagnosis codes listed in Table 4 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 V76.2, V76.47, V76.49, or V15.89 diagnosis code will result in denial of the claim.

Table 4 – Screening Pap Test Diagnosis Codes

ICD-9-CM Code	ICD-9-CM Code Descriptor
V76.2	Special screening for malignant neoplasms; Cervix; Routine cervical Papanicolaou smear. *Excludes: that as part of a general gynecological examination (V72.3)*
V76.47	Special screening for malignant neoplasms; Other sites; Vagina; Vaginal pap smear status-post hysterectomy for non-malignant condition. Use additional code to identify acquired absence of uterus (V45.77). *Excludes: vaginal pap-smear status-post hysterectomy for malignant condition (V67.01)*
V76.49	Special screening for malignant neoplasms; Other sites.
V15.89	Other personal history presenting hazards to health; Other specified personal history presenting hazards to health; Other.

❖ BILLING REQUIREMENTS

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS code (see Table 1) and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

Screening Pap test services may be billed to an FI 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, the appropriate HCPCS code (see Tables 1-3), the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).
Revenue code 0928 is used for billing code Q0091. In addition, CAHs electing Method II report services under revenue codes 096X, 097X, or 098X.

Types of Bills For FIs

As required by CMS, there are five specific bill types that are applicable for screening Pap tests (and two additional bill types in limited situations within Rural Health Clinics and Federally Qualified Health Centers). The applicable FI claim bill types and associated revenue codes for Pap test screening services are:

Table 5 – Facility Type, Type of Bill, and Revenue Codes for Pap Test Screening Services

Facility Type	Type of Bill	Revenue Codes
Hospital Outpatient	13X	0311
Hospital Outpatient - Other	14X	
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X	
SNF Outpatient	23X	
Rural Health Clinic (RHC) (independent and provider-based)	71X	
Federally Qualified Health Center (FQHC) (freestanding and provider-based)	73X	
Critical Access Hospital (CAH)	85X	
Rural Health Clinic (RHC) (independent and provider-based)	**See Additional Billing Instructions for RHCs and FQHCs to follow.**	
Federally Qualified Health Center (FQHC) (freestanding and provider-based)		

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. Also, CMS is eliminating the special HCPCS coding for independent and hospital-based FQHCs billed on TOB 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 0900/0910.

NOTE: Revenue code 0928 must be used for billing code Q0091 (Table 3).

NOTE: CAHs electing method II report services under Revenue Codes 096X, 097X, or 098X.

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

Coding Tips

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.

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.

There are specific billing and coding requirements for both the technical component and the professional 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. The professional component is defined as the physician's interpretation of the results of an examination.

Billing Requirements for the Technical Component for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

The technical component of a screening Pap test is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the Carrier on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format) under the provider's practitioner number.

If the technical component of a screening Pap smear is furnished within a provider-based RHC or FQHC, the base provider of that service bills for the technical portion of the test under their own provider number on TOB 13X, 14X, 22X, 23X, or 85X, as appropriate, and are required to use revenue code 0311.

If the RHC/FQHC is independent the practitioner can bill the carrier under their practitioner number.

NOTE: Independent RHCs and Freestanding FQHCs are freestanding practices that are not part of a hospital, 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.

Billing Requirements for the Professional Component for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

The professional component of a screening Pap test furnished within an RHC/FQHC by a physician or non physician is considered an RHC/FQHC service. RHCs bill on TOB 71X with revenue code 0521 (in rare cases 0522) and FQHCs bill on TOB 73 with revenue code 0520.

In general the RHC/FQHC bills for the visit where the Pap test was obtained and are reimbursed under the all-inclusive rate for the entire visit.

Additional information about the MPFS can be found at: www.cms.hhs.gov/physicians/pfs/ on the Web.

Additional information about the Clinical Laboratory Fee Schedule can be found at: www.cms.hhs.gov/providers/pufdownload/clfcrst.asp on the Web.

Additional information about OPPS can be found at: www.cms.hhs.gov/providers/hopps/ on the Web.

❖ REIMBURSEMENT INFORMATION

General Information

Coverage for the Pap test is provided 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 do not apply. The Coinsurance and deductible do not apply for the laboratory Pap test.

Reimbursement of Claims by Carriers

Reimbursement for screening Pap test services is based on the Clinical Laboratory Fee Schedule or the Medicare Physician Fee Schedule (MPFS).

- Neither the Medicare Part B deductible nor coinsurance or copayment applies for Pap test services paid under the Clinical Laboratory Fee Schedule (codes in Table 1) when billed to the Carrier.

- The Part B deductible is also waived for Pap test services paid under the MPFS (codes in Table 2 and Table 3), however coinsurance applies when billed to the Carrier.

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, the 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 (FIs)

Reimbursement for most screening Pap test services is based on the Clinical Laboratory Fee Schedule or the MPFS.

Neither the Medicare Part B deductible nor coinsurance apply for Pap test services paid under the Clinical Laboratory Fee Schedule (codes in Table 1) when billed to the FI [with the exception of code Q0091 (see Table 3)].

The Medicare Part B deductible is also waived for Pap test services paid under the MPFS (codes in Table 2), however coinsurance applies when billed to the FI.

For code Q0091, the Medicare Part B deductible is waived; however, coinsurance does apply when billed to the FI. Payment for code Q0091 in a hospital outpatient department is based on the OPPS. An 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, or is based on the all-inclusive rate for the technical 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 Pap test within the past 2 years.

- The beneficiary who is at high risk has received a covered Pap test during the past year.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

SCREENING PAP TESTS

Resource Materials

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.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website

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The National Cancer Institute. July 13, 2004. *Cervical Cancer (PDQ): Screening* [online]. Bethesda, MD: The National Cancer Institute, The National Institutes of Health, The U.S. Department of Health and Human Services, 2004 [cited 1 October 2004].

http://www.nci.nih.gov/cancertopics/pdq/screening/cervical/HealthProfessional/page2

National Cancer Institute

www.nci.nih.gov

Beneficiary Notices Initiative Website

www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information

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Beneficiary-related resources can be found in Appendix C of this Guide.

PELVIC SCREENING EXAMINATION

❖ OVERVIEW

A pelvic screening examination is an important part of preventive health care for all adult women. A pelvic examination is performed to help detect precancers, 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.

A pelvic examination can also be used as a prevention tool for detecting, preventing, and treating bladder cancer. Bladder cancer is the tenth most frequent cancer diagnosed in women.[7] In addition, a Medicare pelvic screening examination includes a breast examination, which can be used as a tool for detecting, prevention, and treating breast masses, lumps, and/or cancer.

Fortunately, when many of the illnesses are diagnosed and treated early, they can be slowed or halted. The pelvic screening examination benefit offered by Medicare can help beneficiaries maintain their general overall health of the 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

The high risk factors for cervical and vaginal cancer categories are:

Cervical Cancer High Risk Factors

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of a sexually transmitted disease (including Human papillomavirus HIV infection)
- Fewer than three negative Pap tests within the previous seven years

Vaginal Cancer High Risk Factors

DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

[7] The American Cancer Society, Inc. January 1, 2004. *Detailed Guide: Bladder Cancer* [online]. Atlanta, GA: The American Cancer Society, Inc., 2004 [cited 1 October 2004]. Available from the World Wide Web: (www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_bladder_cancer_44.asp?rnav=cri).

❖ 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, or a 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 pelvic screening examination annually (i.e., at least 11 months have passed following the month in which the last Medicare-covered Pap smear 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, other specified personal history presenting hazards to health) **and** at least 11 months have passed following the month that the last covered pelvic screening 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.

Who are Qualified Physicians and Non physician Practitioners?

Pelvic screening 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.

Covered once every 24 months:

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

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 should include *at least seven* of the following elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge.

AND

- Digital rectal examination including for sphincter tone, presence of hemorrhoids, and rectal masses.
- Pelvic examination (with or without specimen collection for smears and cultures) including:
    - External genitalia (i.e., general appearance, hair distribution, or lesions)
    - Urethral meatus (i.e., size, location, lesions, or prolapse)
    - Urethra (i.e., masses, tenderness, or scarring)
    - Bladder (i.e., fullness, masses, or tenderness)
    - Vagina (i.e., general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele)
    - Cervix (i.e., general appearance, discharge, or lesions)
    - Uterus (i.e., size, contour, position, mobility, tenderness, consistency, descent, or support)
    - Adnexa/parametria (i.e., masses, tenderness, organomegaly, or nodularity)
    - Anus and perineum

Coverage for the pelvic screening examination is provided 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

Medicare-covered pelvic screening examination services are billed using the following Healthcare Common Procedure Coding System (HCPCS) code:

Table 1 – Procedure Code for the Pelvic Screening Examination Service

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

Diagnosis Requirements

When a claim is filed for a screening Pap test and/or pelvic screening, one of the screening ("V") diagnosis codes listed in Table 2 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, is also reported. Failure to report the V76.2, V76.47, V76.49, or V15.89 diagnosis code will result in denial of the claim.

Table 2 – Pelvic Screening Diagnosis Codes

ICD-9-CM Code	ICD-9-CM Code Descriptor
V76.2	Special screening for malignant neoplasms; Cervix; Routine cervical Papanicolaou smear. *Excludes: that as part of a general gynecological examination (V72.3)*
V76.47	Special screening for malignant neoplasms; Other sites; Vagina; Vaginal pap smear status-post hysterectomy for non-malignant condition. Use additional code to identify acquired absence of uterus (V45.77). *Excludes: vaginal pap-smear status-post hysterectomy for malignant condition (V67.01)*
V76.49	Special screening for malignant neoplasms; Other sites.
V15.89	Other personal history presenting hazards to health; Other specified personal history presenting hazards to health; Other.

❖ BILLING REQUIREMENTS

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, HCPCS code G0101 and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

The screening pelvic examination service may be billed to an FI by the technical component category, which is defined as services

Coding Tips

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.

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, the 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.

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, HCPCS code G0101, the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills For FIs

As required by CMS, there are six specific bill types that are applicable for a pelvic examination screening (and two additional bill types in limited situations within RHCs and FQHCs). The applicable FI claim bill types and associated revenue codes for the Pelvic Screening service are:

Table 3 – Facility Type, Type of Bill, and Revenue Codes for Pelvic Screening Services

Facility Type	TOB	Revenue Codes
Hospital Inpatient (for Medicare Part B services)	12X	0770
Hospital Outpatient	13X	
Hospital Outpatient - Other	14X	
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X	
SNF Outpatient	23X	
Critical Access Hospital (CAH)	85X	
Rural Health Clinic (RHC) (independent and provider-based)	**See Additional Billing Instructions for RHCs and FQHCs.**	
Federally Qualified Health Center (FQHC) (freestanding and provider-based)		

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.

There are specific billing and coding requirements for both the technical component and the professional 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. The professional component is defined as the physician's interpretation of the results of an examination.

Billing Requirements for the Technical Component for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

The technical component of a screening pelvic examination is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the Carrier on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format) under the provider's practitioner number.

If the technical component of a screening pelvic examination is furnished within a provider-based RHC or FQHC, the provider of that service bills the FI under bill type 13X, 14X, 22X, 23X, or 85X, as appropriate, using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 0770.

NOTE: Independent RHCs and Freestanding FQHCs are freestanding practices that are not part of a hospital, 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.

Billing Requirements for the Professional Component for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

When the professional component of a screening pelvic examination is furnished within an RHC/FQHC by a physician or non physician this is considered an RHC/FQHC service.

RHCs and FQHCs will bill the FI under bill type 71X or 73X, respectively, for the professional component along with revenue code 052X.

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. Also, CMS is eliminating the special HCPCS coding for independent and hospital-based FQHCs billed on TOB 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 0900/0910.

❖ REIMBURSEMENT INFORMATION

General Information

Medicare provides coverage for the pelvic screening examination as a Medicare Par 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 www.cms.hhs.gov/physicians/cciedits on the Web.

Reimbursement of Claims by Carriers

Reimbursement for the screening pelvic examination service is based on the Medicare Physician Fee Schedule (MPFS).

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for the screening pelvic examination service depends on the type of facility. Table 4 lists the type of payment that facilities receive for pelvic screening examination services.

Table 4 – Types of Payments Received by Facilities for Pelvic Screening Examination Services

If the Facility Is a…	Then Payment is Based On…
Hospital	Outpatient Prospective Payment System (OPPS)
SNF	MPFS
Critical Access Hospital (CAH)	Reasonable Cost Basis
RHC (independent and provider-based)	All-inclusive rate for the professional component. Provider's payment method for the technical component
FQHC (freestanding and provider-based)	

❖ REASONS FOR CLAIM DENIAL

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

- The beneficiary who is not at high risk has received a covered Pelvic Screening within the past 2 years.
- The beneficiary who is at high risk has received a covered Pelvic Screening during the past year.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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.

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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.

PELVIC SCREENING EXAMINATION

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www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_bladder_cancer_44.asp?rnav=cri

National Cancer Institute

www.nci.nih.gov

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COLORECTAL CANCER SCREENING

❖ OVERVIEW

Colorectal cancer is the third leading cause of cancer deaths in the United States, and the risk for it increases with age.[8] The American Cancer Society estimated that 57,100 Americans died of colorectal cancer in 2003.[9] Patients with colon 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. Fortunately, colorectal cancer can be prevented if diagnosed and treated early.

Colorectal cancer is usually found in individuals age 50 or older. Colorectal screenings are performed to diagnose or determine a beneficiary's risk for developing colon cancer. Medicare covers colorectal screening tests to help find pre-cancerous polyps (growths in the colon) so they can be removed before they turn into cancer. Colorectal screening may consist of several different screening tests/procedures to test for polyps or colorectal cancer. Each colorectal screening test/procedure can be used alone or in combination with each other.

Medicare's coverage of colon cancer screening procedures was created as a result of the implementation of the Balanced Budget Act of 1997. The Balanced Budget Act provided coverage of various colon-screening examinations subject to certain coverage, frequency, and payment limitations. Effective July 1, 2001, 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.

The colorectal screening tests/procedures covered by Medicare are:

- Fecal Occult Blood Test (Stool Test)
- Flexible Sigmoidoscopy
- Colonoscopy
- Barium Enema

8 Amanda Gardner. HealthScout. January 19, 2005. *Cancer Now the Leading Killer of Americans* [online] ScoutNews, LLC, HealthScout Network, 2005 [cited 27 January 2005]. Available from the World Wide Web: (www.healthscout.com/news/1/523520/main.html).

9 The American Cancer Society, Inc. January 22, 2003. *ACS Cancer Facts & Figures 2003 Released: Special Section Addresses Smoking Cessation* [online]. Atlanta, GA: The American Cancer Society, Inc., 2003 [cited 28 September 2004]. Available from the World Wide Web: (www.cancer.org/docroot/NWS/content/NWS_1_1x_ACS_Cancer_Facts__Figures_2003_Released.asp).

The ***Fecal Occult Blood Test*** checks for occult or hidden blood in the stool. A beneficiary's health care provider gives a fecal occult blood test card to the beneficiary, and the test can be done at home. Stool samples are taken and placed on the test cards and then returned to the doctor or a laboratory. The fecal occult blood test is:

1. A guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools.

AND

2. 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 used to check for polyps or cancer in the rectum and the lower third of the colon. This procedure is sometimes used in combination with the fecal occult blood test and is administered by inserting a short, thin, flexible, lighted tube into the rectum of the beneficiary.

The ***Colonoscopy*** is a procedure similar to the flexible sigmoidoscopy, except a longer, thin, flexible, lighted tube is used to check for polyps or 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. X-rays are taken of the colon that allows the physician to see the outline of the beneficiary's colon to check for polyps or other abnormalities.

Risk Factors

The high risk factors associated with colorectal cancer include any of the following:

- 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.
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

❖ COVERAGE INFORMATION

Medicare provides coverage of colorectal cancer screening tests for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however there is no minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the beneficiary is at high risk. The covered tests/procedures are:

- Screening fecal occult blood tests
- Screening flexible sigmoidoscopy
- Screening colonoscopy
- Screening barium enema as an alternative to a screening flexible sigmoidoscopy or screening colonoscopy

Coverage for colorectal screening is provided as a Medicare Part B benefit. The beneficiary will pay nothing for the fecal occult blood test (there is no coinsurance or copayment and no deductible for this benefit). For all other procedures, the coinsurance or copayment applies after the yearly Medicare Part Be deductible has been met. If the flexible sigmoidoscopy or colonoscopy procedure is performed in a hospital outpatient department, the beneficiary will pay 25% of the Medicare-approved amount after meeting the yearly Medicare Part B deductible.

The following are the coverage requirements for each screening test/procedure.

Who Can Order the Screening Fecal-Occult Blood Test?

The Screening Fecal-Occult Blood Test requires a written order from 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 Fecal Occult Blood Test

Medicare provides coverage of a screening fecal occult blood test annually (i.e., at least 11 months have passed following the month in which the last covered screening fecal occult blood test was performed) for beneficiaries age 50 and older. This screening requires a written order from the beneficiary's attending physician. Payment may be made for an immunoassay-based fecal occult blood test as an alternative to the guaiac-based fecal occult blood test. However, Medicare will only provide coverage for one fecal occult blood test per year, not both.

Screening Flexible Sigmoidoscopy

Medicare provides coverage of a screening flexible sigmoidoscopy for beneficiaries age 50 or older based on beneficiary risk. A doctor of medicine or osteopathy must perform this screening.

Who Are Qualified Physicians and Non Physician Practitioners?

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 who are not at high risk for colorectal cancer. 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 colonoscopy was performed.

If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which 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.

Screening Colonoscopy

Medicare provides coverage of a screening colonoscopy for beneficiaries age 50 or older based on beneficiary risk. A doctor of medicine or osteopathy must perform this screening.

For Beneficiaries at High Risk for Developing Colorectal Cancer
Medicare provides coverage of a screening colonoscopy once every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening colonoscopy was performed) for beneficiaries at high risk for colorectal cancer.

Screening Colonoscopy
Screening colonoscopies must be ordered and collected by a doctor of medicine or osteopathy

For Beneficiaries Not at High Risk for Developing Colorectal Cancer
Medicare provides coverage of a screening colonoscopy once every 10 years (i.e., at least 119 months have passed following the month in which the last covered screening colonoscopy was performed) but not within 47 months of a previous screening sigmoidoscopy for beneficiaries age 50 or older not at high risk for colorectal cancer.

If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed.

Screening Barium Enema

Medicare provides coverage of a screening barium enema as an alternative to either a screening sigmoidoscopy or a high risk screening colonoscopy. This procedure is covered for beneficiaries based on beneficiary risk.

Screening Barium Enema

The screening barium enema must be ordered and collected by a doctor of medicine or osteopathy.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening barium enema every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening barium enema was performed) for beneficiaries at high risk for colorectal cancer, without regard to age.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening barium enema once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening barium enema was performed) for beneficiaries not at high risk for colorectal cancer, but who are age 50 or older.

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.

❖ CODING AND DIAGNOSIS INFORMATION

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) codes used to report colorectal screening services are:

Table 1 – HCPCS Codes for Colorectal Screening Services

HCPCS Code	HCPCS Code Descriptor
G0104	Colon cancer screening; flexible sigmoidoscopy
G0105	Colon cancer screening; colonoscopy on individual at high risk
G0106	Colon cancer screening; barium enema; as an alternative to G0104, screening sigmoidoscopy
G0107	Colon cancer screening; fecal-occult blood test, 1-3 simultaneous determinations
G0120	Colon cancer screening; barium enema; as an alternative to G0105, screening colonoscopy
G0121	Colon cancer screening; colonoscopy on individuals not meeting criteria for high risk
G0122	Colon cancer screening; barium enema (non-covered)
G0328	Colon cancer screening; as an alternative to G0107; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations

Non-Covered Colorectal Cancer Screening Services

Code **G0122 (colon cancer screening; barium enema)** should be used when a screening barium enema is performed NOT as an alternative to either a screening colonoscopy (code **G0105**) or a screening flexible sigmoidoscopy (code **G0104**). This service is denied as non-covered because it fails to meet the requirements of the benefit. ***The beneficiary is liable for payment.*** Reporting of this non-covered code will also allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes.

Diagnosis Requirements

For the screening colonoscopy, the beneficiary is not required to have any present signs/symptoms. However, when billing 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 some 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	ICD-9-CM 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	ICD-9-CM 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	ICD-9-CM Code Descriptor
558.2	Toxic gastroenteritis and colitis
558.9	Other and unspecified non-infectious gastroenteritis and colitis

❖ BILLING REQUIREMENTS

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS codes and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS codes, the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills For FIs

The FI will reimburse for colorectal screening when submitted on the following type of bills (TOB) and associated revenue codes:

Table 5 – Facility Type, Type of Bill, and Revenue Codes for Colorectal Cancer Screening Services

Facility Type	Type of Bill	Revenue Codes
Hospital Outpatient	13X	See Table 6
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X	See Table 7
SNF Outpatient	23X	
Hospital Outpatient Surgery [subject to Ambulatory Surgical Center (ASC) Payment Limits]	83X	See Table 6
Critical Access Hospital (CAH)	85X	See Table 6

Table 6 – Procedure, Revenue Code, and Associated HCPCS Code for Facilities Using Type of Bills 14X, 83X, and 85X

Screening Test/Procedure	Revenue Code	HCPCS Code
Occult Blood Test	030X	G0107, G0328
Barium Enema	032X	G0106, G0120, (G0122 non-covered)
Flexible Sigmoidoscopy	*	G0104
Colonoscopy-High Risk	*	G0105, G0121

* The appropriate revenue code when reporting any other surgical procedure for bill types 13X, 83X, or 85X.

- Each FI may choose to accept other bill types for the colorectal cancer screening procedures. If another bill type is used other than 13X, 83X, or 85X, contact the local Medicare FI to determine if the particular bill type is allowed.

Additional information about MPFS can be found at: www.cms.hhs.gov/physicians/pfs/ on the Web.

Additional information about the Clinical Laboratory Fee Schedule can be found at: www.cms.hhs.gov/providers/pufdownload/clfcrst.asp on the Web.

Additional information about OPPS can be found at: www.cms.hhs.gov/providers/hopps/ on the Web.

NOTE: Hospital and CAH providers should submit type of bills 13X or 85X. Provider-based ASC facilities that are operated by a hospital not bound by the Outpatient Prospective Payment System (OPPS) requirements should submit type of bill 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 provider should bill on bill type 13X using the discharge date of the hospital stay to avoid editing.

Special Billing Instructions for SNFs

When colorectal screening tests are provided to inpatients of a SNF, the test should be billed on a 22X bill type using the actual date of service.

SNFs cannot bill HCPCS codes G0105 or G0121 for a screening colonoscopy, or G0120 for a barium enema as an alternative to a screening colonoscopy. These services must be provided in a hospital, CAH, or ASC. However, SNFs may bill screening barium enema tests every 48 months as a substitute for a flexible sigmoidoscopy.

Table 7 – Procedure, Revenue Code, and Associated HCPCS Code for SNFs

Screening Test/Procedure	Revenue Code	HCPCS Code
Fecal Occult Blood Test	030X	G0107
Fecal Occult Blood Test, Immunoassay	030X	G0328
Barium Enema	032X	G0106
Flexible Sigmoidoscopy	075X	G0104

❖ REIMBURSEMENT INFORMATION

Reimbursement of Claims by Carriers

Reimbursement for colorectal screening procedures is paid under the Medicare Physician Fee Schedule (MPFS), when billed to the Carrier. Deductible and coinsurance apply.

Reimbursement for fecal occult blood tests 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.

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at www.cms.hhs.gov/physicians/cciedits on the Web.

Payment by Carriers 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 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 a modifier of "-53" to indicate that the procedure was interrupted.

When a covered colonoscopy is attempted in an ambulatory surgery center (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 the 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 it is needed by the Medicare Contractor 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 (FIs)

Reimbursement for colorectal screening procures is dependent upon the type of facility. The following table 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 (G0107 and G0328)	CAH	Reasonable Cost Basis	Deductible and coinsurance do not apply for this type of screening
	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.)	
Flexible Sigmoidoscopy (G0104)	CAH	Reasonable Cost Basis	Deductible and coinsurance apply 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.
	Hospital Outpatient Departments	OPPS	
	Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	MPFS	
Colonoscopy (G0105)	CAH	Reasonable Cost Basis	Deductible and 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.
	Hospital Outpatient Departments	OPPS	
Barium Enemas (G0106 and G0120)	CAH	Reasonable Cost Basis	Deductible and 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.
	Hospital Outpatient Departments	OPPS	
	SNF	MPFS	

In addition, the colorectal screening codes must be paid at rates consistent with the colorectal diagnostic codes.

Payment by FIs 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 a modifier of "-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 it is needed by the Medicare Contractor 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.

NOTE: Payment for covered incomplete screening colonoscopies should be consistent with payment methodologies currently in place for complete screening colonoscopies, including those contained in 42 CFR 419.44(b).

Search the Federal Register for specific sections at: www.gpoaccess.gov/cfr/retrieve.html on the Web.

Critical Access Hospital (CAH) Payment by Fiscal Intermediary (FI) 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 the 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 not at high risk and is under age 50.
- The beneficiary does not meet the criteria of being at high risk of developing colorectal cancer.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

COLORECTAL CANCER SCREENING

Resource Materials

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.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule and the OPPS.
www.cms.hhs.gov/providers

Medicare Learning Network

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

Beneficiary Notices Initiative Website

www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information

www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website

www.cms.hhs.gov/physicians/cciedits

The National Cancer Institute' s *Colorectal Cancer Prevention*

www.nci.nih.gov/cancertopics/pdq/prevention/colorectal/Patient/page2

The American Cancer Society's ACS Cancer Facts & Figures 2003

www.cancer.org/docroot/NWS/content/NWS_1_1x_ACS_Cancer_Facts__Figures_2003_Released.asp

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.
www.wpc-edi.com/Codes/Codes.asp

Beneficiary-related resources can be found in Appendix C of this Guide.

PROSTATE CANCER SCREENING

❖ OVERVIEW

Prostate cancer is the second leading cause of cancer-related death in men and about 70% of all diagnosed prostate cancers are found in men age 65 or older.[10] Medicare provides coverage for prostate cancer screening tests/procedures for the early detection of prostate cancer. Medicare provides coverage of the two most common tests used by physicians to detect prostate cancer, *both* 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, subject to coverage, frequency, and payment limitations. Effective for services furnished on or after January 1, 2000, Medicare will cover prostate cancer screening tests/procedures for the early detection of prostate cancer.

The Prostate Specific Antigen (PSA) Blood Test

Prostate specific antigen is a protein produced by the cells of the prostate gland. The U.S. 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 test to monitor patients with a history of prostate cancer to determine if the cancer reoccurs[11].

PSA is a tumor marker for adenocarcinoma of the prostate that can help to predict residual tumor 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. PSA also aids in managing prostate cancer patients and in detecting metastatic or persistent disease in patients following treatment. PSA 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.

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[10] The National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control. 2004. *Prostate Cancer: The Public Health Perspective* [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, 2004 [cited 15 September 2004]. Available from the World Wide Web: (www.cdc.gov/cancer/prostate/prostate.htm).

[11] The Cancer Information Service, a program of The National Cancer Institute, the U.S. Department of Health and Human Services, National Institutes of Health, *The Prostate-Specific Antigen (PSA) Test: Questions and Answers*, [cited 17 November 2004]. Available from the World Wide Web: (http://cis.nci.nih.gov/fact/5_29.htm).

The PSA blood test is not perfect; however, it is the best test currently available for the early detection of prostate cancer. Since providers began using this test, the number of prostate cancers found at an early, curable stage has increased.

The Digital Rectal Examination (DRE)

The DRE is a clinical examination of an individual's prostate for abnormalities such as swelling and nodules 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 displays the order of prostate cancer risk among ethnic groups from highest to lowest:

- African-Americans
- Caucasians
- Hispanics
- Asians
- Pacific Islanders
- Native Americans

❖ COVERAGE INFORMATION

Medicare covers prostate cancer screening tests once every 12 months for all male beneficiaries age 50 and older (coverage begins the day after the beneficiary's 50th birthday) for the early detection of prostate cancer.

The Prostate Specific Antigen (PSA) Blood Test

Medicare pays for a PSA blood test annually (i.e., at least 11 months have passed following the month in which the last Medicare-covered PSA test was performed) for male beneficiaries age 50 or older (coverage begins at least one day after reaching age 50).

A doctor of medicine or osteopathy, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife must order PSA screening for Medicare coverage. The screening provider must be authorized under State law to perform the examination, be fully knowledgeable about the beneficiary's medical condition, and be responsible for using the results of any examination (test) performed in the overall management of the beneficiary's specific medical problem.

Coverage of a screening PSA blood test is provided as a Medicare Part B benefit. The beneficiary will pay nothing for the PSA blood test. There is no coinsurance or copayment for the PSA blood test and no Medicare Part B deductible

The Digital Rectal Examination (DRE)

Medicare provides coverage of a screening DRE annually (i.e., at least 11 months have passed following the month in which the last Medicare-covered DRE was performed) for male beneficiaries age 50 or older (coverage begins at least one day after reaching age 50).

A doctor of medicine or osteopathy, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife must perform this screening for Medicare coverage. The screening provider must be authorized under State law to perform the examination, be fully knowledgeable about the beneficiary's medical condition, and be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

Coverage of a screening DRE is provided 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

Use the following Healthcare Common Procedure Coding System (HCPCS) codes to report prostate screening services:

Table 1 – HCPCS Codes for Prostate Cancer Screening Tests

HCPCS Code	HCPCS Code Descriptor
G0102	Prostate Cancer Screening, DRE
G0103	Prostate Cancer Screening, PSA Test, Total

Diagnosis Requirements

There are no specific diagnosis requirements for prostate screening tests and procedures. However, if screening is the reason for the test and/or procedure, the appropriate screening ("V") diagnosis code must be chosen when billing Medicare. The screening diagnosis code of V76.44 (Special Screening for Malignant Neoplasms, Prostate) is reported.

❖ BILLING REQUIREMENTS

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS code G0102 or G0103, and the corresponding diagnosis code, must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS codes G0102 or G0103, the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills for FIs

The FI will reimburse for prostate screening services when submitted with the following type of bills (TOB) and associated revenue codes for prostate cancer services:

Table 2 – Facility Type, Type of Bill, and Revenue Codes for Prostate Screening Services

Facility Type	Type of Bill	Revenue Codes
Hospital Inpatient (for Medicare Part B services)	12X	0770 – DRE 030X – PSA
Hospital Outpatient	13X	
Hospital Outpatient - Other	14X	
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X	
SNF Outpatient	23X	
Rural Health Clinic (RHC) (independent and provider-based)	71X	
Federally Qualified Health Center (FQHC) (freestanding and provider-based)	73X	
Comprehensive Outpatient Rehabilitation Facility	75X	
Critical Access Hospital (CAH)	85X	

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. Also, CMS is eliminating the special HCPCS coding for independent and hospital-based FQHCs billed on TOB 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 0900/0910.

Additional information about the MPFS can be found at: www.cms.hhs.gov/physicians/pfs/.

Additional information about the Clinical Laboratory Fee Schedule can be found at: http://www.cms.hhs.gov/providers/pufdownload/clfcrst.asp.

Additional information about OPPS can be found at: www.cms.hhs.gov/providers/hopps/.

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at www.cms.hhs.gov/physicians/cciedits.

❖ REIMBURSEMENT INFORMATION

Reimbursement of Claims by Carriers

Reimbursement for the DRE (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 applies when this service is provided.

Reimbursement for PSA (G0103) is based on the Clinical Laboratory Fee Schedule and is never bundled. The deductible and coinsurance or copayments do not apply when this service is provided.

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for the DRE (G0102) for FI bill types 22x, 23x and 75 is based on the MPFS; reimbursement for PSA (G0103) is based on the Clinical Laboratory Fee Schedule. These tests are not bundled when billed to FIs. Table 3 provides a reference for the payment systems for each of the institutional provider bill types.

Table 3 – Bill Types and Types of Payments Received by Facilities for Prostate Screening Services

If the Bill Type 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)

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) must include the charges on the claims for future inclusion in encounter rate calculations.

❖ REASONS FOR CLAIM DENIAL

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

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp.

- The beneficiary is not at least age 50.
- 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 only).

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

PROSTATE CANCER SCREENING

Resource Materials

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.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule and the OPPS.
www.cms.hhs.gov/providers

Medicare Learning Network

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

Beneficiary Notices Initiative Website

www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information

www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website

www.cms.hhs.gov/physicians/cciedits

Prostate Cancer: The Public Health Perspective

An informational Fact Sheet produced by the Centers for Disease Control and Prevention's Center for Chronic Disease Prevention and Health Promotion.
www.cdc.gov/cancer/prostate/prostate.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://cis.nci.nih.gov/fact/5_29.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.
www.wpc-edi.com/Codes/Codes.asp

Beneficiary-related resources can be found in Appendix C of this Guide.

INFLUENZA, PNEUMOCOCCAL, AND HEPATITIS B VACCINATIONS

❖ OVERVIEW

Influenza (commonly called the flu) is a serious illness that can lead to pneumonia. At least 45,000 Americans die each year from influenza and pneumonia, the sixth leading cause of death in the United States. 90 percent of these deaths are among people 65 years of age or over.[12] The Hepatitis B Virus (HBV) 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 HBV. 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, in addition to vaccination administration.

Advisory Committee on Immunization Practices (ACIP)

The Centers for Disease Control and Prevention's (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 www.cdc.gov on the Web.

❖ INFLUENZA (FLU)

The risks for complications, hospitalizations, and deaths from influenza are higher among person 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. Older adults account for more than 90% of deaths attributed to pneumonia and influenza. Medicare provides coverage for the influenza 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 of the high risk or priority groups:

[12] The Centers for Medicare & Medicaid Services. 2004. *Fight Flu and Pneumonia* [online]. Baltimore, MD: The Centers for Medicare & Medicaid Services, The U.S. Department of Health and Human Services, 2004 [cited 15 September 2004]. Available from the World Wide Web: (www.medicare.gov/health/fludetails.asp).

Risk Factors for Influenza

ACIP identifies the following individuals as being in a high risk group for serious complications from influenza:

- Individuals aged 65 or older
- Children less than 3 years old
- All women who will be pregnant during the flu season
- Individuals of any age who have certain underlying health conditions such as heart or lung disease, transplant recipients, or persons with AIDS

ACIP also identifies the following individuals as being in a priority group:

- Residents of nursing homes and long-term care facilities.
- Children aged 2 - 18 years old on chronic aspirin therapy.
- Health care workers involved in direct patient care.
- Out-of-home caregivers and household contacts of children less than 6 months of age or person in the high risk groups.

NOTE: All individuals 65 years of age and older should get both the influenza and pneumococcal vaccinations. Medicare beneficiaries who are under 65 but are in one or more of the high risk or priority groups or that have chronic illness, such as heart disease, lung disease, diabetes or end-stage renal disease should get the influenza vaccination.

Individuals in the following groups should not receive influenza vaccine without the recommendation of their physicians:

- Individuals with a severe allergy (i.e., anaphylactic allergic reaction) to hens' eggs
- Individuals who previously had onset of Guillain-Barrẻ syndrome during the 6 weeks after receiving influenza vaccine

❖ 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 vaccine per influenza season for all beneficiaries. This may mean that a beneficiary will receive more than one influenza vaccination in a 12-month period. However, Medicare provides coverage for more than one influenza vaccination per influenza season if it is reasonable and medically necessary.

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.

Who Are Qualified Physicians and Non Physician Practitioners?

Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Coverage for the influenza vaccination is provided as a Medicare Part B benefit. If the beneficiary receives the service from a Medicare enrolled provider who accepts assignment, the beneficiary will pay nothing (there is no deductible or copayment for this benefit).

❖ CODING AND DIAGNOSIS INFORMATION

Procedure Codes and Descriptors

Medicare-covered influenza vaccination services are reported by using the following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes: Charges for other services may be listed on the same bill as influenza; however, the applicable codes for the additional services must be used.

Table 1 – HCPCS/CPT Codes for Influenza Vaccine and Administration

HCPCS/CPT Code	Code Descriptors
90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use
G0008	Administration of the Influenza virus vaccine

Diagnosis Requirements

When a claim is filed for a visit and the sole purpose was to receive the influenza vaccine, the diagnosis code V04.81 (Need for prophylactic vaccination and inoculation against certain viral diseases; influenza) must be reported.

❖ BILLING REQUIREMENTS

General Requirements

Non-governmental entities (providers, physicians, or suppliers) that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the benefit, free of charge, to Medicare beneficiaries and not bill Medicare. However, a non-governmental entity that does not charge patients who are unable to pay or reduces its charge for patients of limited means (sliding fee scale), but does expect to be paid if a patient has health insurance that covers the items or services provided, may bill Medicare and receive Medicare Program payment.

State and local government entities (such as public health clinics) may bill Medicare for immunizations given to beneficiaries even if they provide immunizations free to all patients, regardless of their ability to pay.

Additional Billing Guidelines for Non-Traditional Providers Billing Influenza Immunizations

Nontraditional providers and suppliers such as drug stores, senior centers, shopping malls, and self-employed nurses may bill a Carrier for influenza vaccinations or PPV if the provider meets State licensure requirements to furnish and administer influenza vaccinations. Providers and suppliers should contact their local Carrier provider enrollment department to enroll in the Medicare Program.

A registered nurse employed by a physician may use the physician's provider number if the nurse, in a location other than the physician's office, provides the influenza or PPV vaccinations. If the nurse is not working for the physician when the services are provided (e.g., a nurse is "moonlighting", administering influenza vaccinations or PPVs at a shopping mall at his or her own direction and not that of the physician), the nurse may obtain a provider number and bill the Carrier directly. However, if the nurse is working for the physician when the services are provided, the nurse would use the physician's provider number. The following providers of services may bill FIs for the influenza and PPV vaccines:

- Hospitals
- Skilled Nursing Facilities (SNFs)
- Critical Access Hospitals (CAHs)
- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Independent Renal Dialysis Facilities (RDFs)

Since the influenza and Pneumococcal Polysaccharide Vaccine (PPV) benefits do 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 influenza shot and pays $2.50 of the cost from its budget may bill the Carrier the $5.00 cost that is not paid out of its budget. When an entity receives donated influenza or PPV 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 PPV vaccination.**

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS code for vaccine administration, G0008, vaccine 90657 or 90658, and the corresponding ICD-9-CM diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS code for vaccine administration, G0008, vaccine 90657 or 90658, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

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 HHA benefit when the sole purpose for an HHA visit is to administer a vaccine (influenza, PPV, or hepatitis B). However, the vaccine and its administration are covered under the HHA 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)

Independent RHCs must use revenue code 521 together with the appropriate procedure code when billing Medicare for the influenza, hepatitis B, and/or pneumococcal vaccination. RHCs adhere to guidelines in Section 614 of the RHC/FQHC Manual, and do not include charges for the vaccine or its administration on the CMS-1450. For independent and provider-based RHCs and FQHCs, payment for the hepatitis B vaccine is included in the all-inclusive rate. RHCs and FQHCs do not bill for a visit when the only service involved is the administration of the hepatitis B vaccine.

Types of Bills for FIs

The FI will pay claims submitted on the following applicable type of bills (TOB) and associated revenue codes for the influenza vaccination:

Table 2 – Facility Type, Type of Bill, and Revenue Codes for Influenza Vaccination

Facility Type	TOB	Revenue Codes
Hospital Outpatient	13X	0636 - vaccine 0771 - administration
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X	
SNF Outpatient	23X	
Home Health Agency (HHA)	34X	
Renal Dialysis Facility (RDF)	72X	
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	
Critical Access Hospital (CAH)	85X	

Special Billing Instructions

- Other Charges - Other charges may be listed on the same bill; however, the provider must include the applicable codes for the additional charges.

- No Legal Obligation to Pay – Non-governmental entities 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.

- Certified Part A Providers - With the exception of hospice providers, certified Part A providers must bill the FI for this Part B benefit.

- Hospice Providers - Hospice providers bill the Carrier using Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

- Non-Medicare Participating Providers - Non-Medicare participating provider facilities bill the local Carrier.

- 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 Part B Carrier.

- Hospitals - Hospitals bill the FI for inpatient vaccination.

- RHCs and FQHCs - Independent and provider-based RHCs and FQHCs do not include charges for influenza on claims. These providers count visits under current procedures except when the only service involved is the administration of influenza. If there is another reason for the visit, the RHC/FQHC is to bill for the visit without adding the cost of the influenza to the charge for the visit on the bill.

- Dialysis Patients - On claims, regardless of where the influenza vaccine is administered to a dialysis patient of a hospital or hospital-based renal dialysis facility, the hospital bills the FI.

❖ REIMBURSEMENT INFORMATION

General Information

Medicare pays 100% of the Medicare-approved charge or the submitted charge, whichever is lower. Neither the annual deductible nor the coinsurance applies. Therefore, if a beneficiary receives an influenza vaccination from a physician, provider, or supplier who agrees to accept assignment (i.e., agrees to accept Medicare payment as payment in full), there is no cost to the beneficiary. If a beneficiary receives an influenza vaccination from a physician, provider, or supplier who does not accept assignment, the physician may collect his or her usual charge for the *administration* of the vaccine but may not collect any fee up front for *the vaccine* and must accept the Medicare-approved amount. The flu vaccine is subject to mandatory assignment regardless of whether the physician normally does not accept assignment. In addition:

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at www.cms.hhs.gov/physicians/cciedits on the Web.

- A physician, provider, or supplier may not charge a Medicare beneficiary more for an immunization than he or she charges a non-Medicare patient.

- 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 vaccine and the PPV on the same day.

- HCPCS code G0008 (administration of influenza vaccine) may be paid in addition to other services, including Evaluation and Management (E/M) services, and is NOT subject to rebundling charges.

- When a physician sees a beneficiary for the sole purpose of administering the influenza 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.

- Providers enrolled as a provider specialty type 73, Mass Immunization Roster Biller, must roster bill and must accept assignment on both the administration and the vaccine. Refer to the *Roster Billing* section of this Guide for more information on this type of billing.

Reimbursement of Claims by Carriers

Reimbursement for the administration of the influenza 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: www.cms.hhs.gov/physicians/pfs/ on the Web.

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 vaccine. They may not collect payment from beneficiaries.

Nonparticipating 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% of the Medicare-allowed amount.
- Nonparticipating physicians, providers, and suppliers who do not accept assignment may collect payment from the beneficiary for the administration of the vaccine, but they must submit an unassigned claim on the beneficiary's behalf. They may not collect payment for the vaccine as it is always subject to mandatory assignment.
- The limiting charge provision does not apply to the influenza benefit. Nonparticipating physicians and suppliers who do not accept assignment for the administration of the influenza 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, they must always accept assignment for the *vaccine* and may not collect payment up front from the beneficiary. When services are provided by non-participating physicians or suppliers, 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 5% payment reduction for physicians who do not accept assignment does not apply to the administration of the influenza vaccine. Only items and services covered under the limiting charge are subject to the 5% payment reduction.

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for the influenza vaccine and its administration is based on reasonable cost. Medicare payments, for given items or services, are determined by statute; it would require Congressional legislation for Medicare to pay a nationwide rate.

❖ REASONS FOR CLAIM DENIAL

An example of a situation when Medicare may deny coverage of influenza vaccination is when a beneficiary requests more than one influenza vaccination during the same flu season and the provider cannot justify medical necessity.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

❖ THE PNEUMOCOCCAL POLYSACCHARIDE VACCINE (PPV)

Coverage of PPV and its administration was added to the Medicare Program on July 1, 1981. Pneumococcal diseases are 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 disease kills more people in the United States each year than all other vaccine-preventable diseases combined. Pneumococcal vaccine is very good at preventing severe disease, hospitalization, and death. However it is not guaranteed to prevent all symptoms in all people. Medicare provides coverage for the pneumococcal polysaccharide vaccine and its administration for all Medicare beneficiaries regardless of risk for the disease; however, some individuals are at greater risk for pneumococcal disease.

Risk Factors for Pneumococcal Infection

The Centers for Disease Control and Prevention (CDC) identifies the following high priority target groups for the pneumococcal vaccination to include:

- Individuals age 65 or older
- Individuals with a serious long-term health problem such as heart disease, sickle cell disease, alcoholism, leaks of cerebrospinal fluid, lung disease (not including asthma), diabetes, or liver cirrhosis
- Individuals with a lowered resistance to infection due to Hodgkin's disease; multiple myeloma; cancer treatment with x-rays or drugs; treatment with long-term steroids; bone marrow or organ transplant; kidney failure; HIV/AIDS; lymphoma, leukemia, or other cancers; nephritic syndrome; damaged spleen or no spleen
- Alaskan Natives or individuals from certain Native American populations

Note: All individuals 65 years of age and older should get both the influenza and pneumococcal vaccinations.

❖ COVERAGE INFORMATION

Medicare provides coverage for PPV once in a lifetime for all Medicare beneficiaries. Medicare may provide additional vaccinations based on risk. (See revaccination guidelines below.)

PPV is typically administered to a beneficiary once in a lifetime, except for beneficiaries at highest risk for pneumococcal disease. It is not necessary for a beneficiary to provide his or her vaccination status, nor is it necessary for the provider to review the beneficiary's medical records. Individuals and entities providing PPVs to Medicare beneficiaries may rely on a verbal account of vaccination status if provided by a competent beneficiary. If a beneficiary, who is not at highest risk, is revaccinated because of uncertainty about his or her PPV vaccination status, Medicare will pay for the PPV revaccination.

Prior to vaccination, physicians should ask beneficiaries if they have been vaccinated with PPV. If beneficiaries are uncertain of whether they have been vaccinated within the past 5 years, the provider should administer the vaccine. If beneficiaries are certain they have been vaccinated within the past 5 years, the vaccine should not be administered.

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.

Who Are Qualified Physicians and Non Physician Practitioners?

For coverage purposes, Medicare does not require that a doctor of medicine or osteopathy order the PPV vaccine and its administration. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Revaccination

Beneficiaries considered to be at high risk may be **revaccinated** if at least five years have passed since the last covered PPV or are revaccinated because they are unsure of their vaccination status. Revaccination is limited to beneficiaries at the highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels. This group includes persons with:

- Functional or anatomic asplenia (e.g., sickle cell disease, splenectomy)
- HIV infection
- Leukemia
- Lymphoma
- Hodgkin's disease
- Multiple myeloma
- Generalized malignancy
- Chronic renal failure
- Nephrotic syndrome
- Other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy

Note: Individuals 65 years of age or older should be administered a second dose of pneumococcal vaccine if they received the first dose 5 or more years previously, and were less than 65 years of age at the time of the first dose.

Coverage for the PPV is provided as a Medicare Part B benefit. If the beneficiary receives the service from a Medicare enrolled participating physician, the beneficiary will pay nothing (there is no deductible or copayment) for this benefit.

❖ CODING AND DIAGNOSIS INFORMATION

Procedure Codes and Descriptors

Medicare PPV vaccination services are reported by using the following Healthcare Common Procedure Coding System (HCPCS) codes. Charges for other services may be listed on the same bill as PPV however; the applicable codes for the additional services must be used.

Table 3 – HCPCS/CPT Codes for PPV and Administration

HCPCS/CPT Code	HCPCS/CPT Code Descriptors
90732	PPV, 23-valent, adult or immunosuppressed dosage, for subcutaneous or intramuscular use
G0009	Administration of the pneumococcal vaccine

Diagnosis Requirements

When a claim is filed for a visit and the sole purpose was to receive PPV, the diagnosis code V03.82 [Need for prophylactic vaccination and inoculation against bacterial diseases; other specified vaccinations against single bacterial diseases; Streptococcus pneumoniae (pneumococcus)] must be reported.

❖ BILLING REQUIREMENTS

General Requirements

Non-governmental entities (providers, physicians, or suppliers) that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the benefit, free of charge, to Medicare beneficiaries and not bill Medicare. However, a non-governmental entity that does not charge patients who are unable to pay or reduces its charge for patients of limited means (sliding fee scale), but does expect to be paid if a patient has health insurance that covers the items or services provided, may bill Medicare and receive Medicare Program payment.

State and local government entities (such as public health clinics) may bill Medicare for immunizations given to beneficiaries even if they provide immunizations free to all patients, regardless of their ability to pay.

Since the influenza and PPV benefits do 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

Additional Billing Guidelines for Non-Traditional Providers Billing PPV Immunizations

Nontraditional providers and suppliers such as drug stores, senior centers, shopping malls, and self-employed nurses may bill a Carrier for influenza vaccinations or PPV if the provider meets State licensure requirements to furnish and administer influenza vaccinations. Providers and suppliers should contact their local Carrier provider enrollment department to enroll in the Medicare Program.

A registered nurse employed by a physician may use the physician's provider number if the nurse, in a location other than the physician's office, provides the influenza or PPV vaccinations. If the nurse is not working for the physician when the services are provided (e.g., a nurse is "moonlighting", administering influenza vaccinations or PPVs at a shopping mall at his or her own direction and not that of the physician), the nurse may obtain a provider number and bill the Carrier directly. However, if the nurse is working for the physician when the services are provided, the nurse would use the physician's provider number. The following providers of services may bill FIs for the influenza and PPV vaccines:

- Hospitals
- Skilled Nursing Facilities (SNFs)
- Critical Access Hospitals (CAHs)
- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Independent Renal Dialysis Facilities (RDFs)

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 influenza shot and pays $2.50 of the cost from its budget may bill the Carrier the $5.00 cost that is not paid out of its budget. When an entity receives donated influenza or PPV 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 PPV vaccination.

With the exception of hospice providers, certified Part A providers must bill the FI for this Part B benefit. Hospice providers bill the Carrier using Form CMS-1500 (or the HIPAA 837 Professional electronic claim format). Non-Medicare participating provider facilities bill the local Carrier. HHAs that have a Medicare-certified component and a non-Medicare certified component might elect to furnish the PPV benefit through the non-certified component and bill the Part B Carrier.

Billing and Coding Requirements When Submitting to Carriers

When submitting claims, the appropriate HCPCS code for vaccine administration, G0009, vaccine 90732, and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims, the appropriate HCPCS code for vaccine administration, G0009, vaccine 90732, the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Additional Coverage Guidelines for Billing for PPV Immunizations

Home Health Agencies (HHAs)

Medicare will not pay for a skilled nursing visit by an HHA nurse under the HHA benefit when the sole purpose for an HHA visit is to administer a vaccine (influenza, PPV, or hepatitis B). However, the vaccine and its administration are covered under the HHA 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)

Independent RHCs must use Revenue Code 521 together with the appropriate procedure code when billing Medicare for the influenza, hepatitis B, and/or pneumococcal vaccination. RHCs adhere to guidelines in Section 614 of the RHC/FQHC Manual, and do not include charges for the vaccine or its administration on the CMS-1450. For independent and provider-based RHCs and FQHCs, payment for the hepatitis B vaccine is included in the all-inclusive rate. RHCs and FQHCs do not bill for a visit when the only service involved is the administration of the hepatitis B vaccine.

Types of Bills for FIs

As required by CMS, there are seven specific bill types that are applicable for PPV vaccination. The applicable bill types and associated revenue codes for PPV vaccination are:

Table 4 – Facility Type, Type of Bill, and Revenue Codes for PPV Vaccination

Facility Type	Type of Bill	Revenue Codes
Hospital Outpatient	13X	0636 - vaccine 0771 - administration
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X	
SNF Outpatient	23X	
Home Health Agency	34X	
Renal Dialysis Facility (RDF)	72X	
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	
Critical Access Hospital (CAH)	85X	

Special Billing Information

- Other Charges - Other charges may be listed on the same bill; however the provider must include the applicable codes for the additional charges.

- No Legal Obligation to Pay – Non-governmental entities 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.

- Hospitals - Hospitals bill the FI for inpatient vaccination.

- RHCs and FQHCs - Independent and provider-based RHCs and FQHCs do not include charges for PPV on claims. They count visits under current procedures except that they do not count as visits when the only service involved is the administration of PPV. If there was another reason for the visit, the RHC/FQHC is to bill for the visit without adding the cost of the PPV to the charge for the visit on the bill FIs pay at the time of cost settlement and adjust interim rates to account for this additional cost if they determine that the payment is more than a negligible amount.
- Dialysis Patients – On claims, regardless of where PPV is administered to a dialysis patient of a hospital or hospital-based renal dialysis facility, the hospital bills the FI.

❖ REIMBURSEMENT INFORMATION

General Information

Medicare pays 100% of the Medicare-approved charge or the submitted charge, whichever is lower. Neither the annual deductible nor the coinsurance or copayment applies. Therefore, if a beneficiary receives a pneumococcal vaccine from a physician, provider, or supplier who agrees to accept assignment (i.e., agrees to accept Medicare payment as payment in full), there is no cost to the beneficiary. If a beneficiary receives a PPV from a physician, provider, or supplier who does not accept assignment for the *administration* of the vaccine, the physician may collect his or her usual charge for the administration but may not collect any fee up front for *the vaccine* and must accept the Medicare-approved amount. The vaccine is subject to mandatory assignment regardless of whether the physician normally does not accept assignment. In addition:

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at www.cms.hhs.gov/physicians/cciedits on the Web.

Additional information about MPFS can be found at: www.cms.hhs.gov/physicians/pfs/ on the Web.

- Medicare payment by Carriers for the administration of PPV is linked to payment for services under the 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.

- A physician, provider, or supplier may not charge a Medicare beneficiary more for an immunization than he or she charges a non-Medicare patient.

- 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 vaccine and the PPV on the same day.

- HCPCS code G0009 (administration of PPV) 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 PPV, 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.
- Providers enrolled as a provider specialty type 73, Mass Immunization Roster Biller must roster bill and accept assignment on both the administration and the vaccine. Refer to the *Roster Billing* section in this Guide for more information on this type of billing.

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 PPV. They may not collect payment from beneficiaries.

Nonparticipating 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% of the Medicare-allowed amount.

- Nonparticipating physicians, providers, and suppliers that do not accept assignment may collect payment from the beneficiary, but they must submit an unassigned claim on the beneficiary's behalf.

- The limiting charge provision does not apply to the PPV benefit. Nonparticipating physicians and suppliers that do not accept assignment for the administration of the PPV 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, they must always accept assignment for the vaccine and may not collect up front from the beneficiary. When services are provided by non-participating physicians or suppliers, the beneficiary is responsible for paying the difference between what the physician or supplier charges and the amount Medicare allows.

- The 5% payment reduction for physicians who do not accept assignment does not apply to the administration of PPV. Only items and services covered under limiting charge are subject to the 5% payment reduction.

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for PPV and its administration is based on reasonable cost. Medicare payments, for given items or services, are determined by statute; it would require Congressional legislation for Medicare to pay a nationwide rate.

❖ REASONS FOR CLAIM DENIAL

The following are examples of situations where Medicare may deny coverage of PPV vaccination:

- The beneficiary is not at risk of contracting PPV.
- The beneficiary is not at least age 65.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

❖ THE HEPATITIS B VIRUS (HBV) VACCINE

Coverage of the hepatitis B vaccine and its administration was added to the Medicare Program in 1984. Hepatitis B is a serious disease caused by a virus that attacks the liver. The virus, which is called Hepatitis B Virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. Medicare provides coverage for certain beneficiaries at medium to high risk for hepatitis B.

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 hepatitis B.

<u>High-risk groups for whom vaccination is recommended include:</u>

- 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 a Hepatitis B Virus (HBV) carrier
- Homosexual men
- Illicit injectable drug users

<u>Intermediate risk groups for whom vaccination is recommended include:</u>

- Staff in institutions for the mentally handicapped
- 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 hepatitis B if they have laboratory evidence positive for antibodies to hepatitis B. (ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy.)*

Who Are Qualified Physicians and Non Physician Practitioners?

For Medicare program purposes, the Hepatitis B vaccine may be administered upon the order of a doctor of medicine or osteopathy by home health agencies, skilled nursing facilities, ESRD facilities, hospital outpatient departments, persons recognized under the incident to physicians' services provision of law, and doctors of medicine and osteopathy.

❖ COVERAGE INFORMATION

Medicare provides coverage for the hepatitis B vaccine and its administration, for beneficiaries at high or intermediate risk of contracting hepatitis B, if ordered by a doctor of medicine or osteopathy.

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.

Coverage for the hepatitis B vaccine is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. **Procedure Codes and Descriptors**

Medicare-covered hepatitis B vaccination services are reported by using the following Healthcare Common Procedure Coding System (HCPCS) codes:

Table 5 – HCPCS/CPT Codes for Hepatitis B Vaccine and Administration

HCPCS/CPT Code	HCPCS/CPT Code Descriptors
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3dose 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 code for Hepatitis B vaccine

Diagnosis Requirements

The provider of the vaccine must report a diagnosis code for each vaccine if the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim. When providing hepatitis B vaccinations, diagnosis code V05.3 (Need for prophylactic vaccination and inoculation against single diseases; Viral hepatitis) must be present.

❖ BILLING REQUIREMENTS

General Requirements

Non-governmental entities (providers, physicians, or suppliers) that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the benefit, free of charge, to Medicare beneficiaries and not bill Medicare. However, a non-governmental entity that does not charge patients who are unable to pay or reduces its charge for patients of limited means (sliding fee scale), but does expect to be paid if a patient has health insurance that covers the items or services provided, may bill Medicare and receive Medicare Program payment.

State and local government entities (such as public health clinics) may bill Medicare for immunizations given to beneficiaries even if they provide immunizations free to all patients, regardless of their ability to pay.

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS code for vaccine administration, G0010, appropriate vaccine code (shown in Table 5), and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims, the appropriate HCPCS code for vaccine administration, G0010, appropriate vaccine code (shown in Table 5), the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

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 HHA benefit when the sole purpose for an HHA visit is to administer a vaccine (influenza, PPV, or hepatitis B). However, the vaccine and its administration are covered under the HHA 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)

Independent RHCs must use Revenue Code 521 together with the appropriate procedure code when billing Medicare for the influenza, hepatitis B, and/or pneumococcal vaccination. RHCs adhere to guidelines in Section 614 of the RHC/FQHC Manual, and do not include charges for the vaccine or its administration on the CMS-1450. For independent and provider-based RHCs and FQHCs, payment for the hepatitis B vaccine is included in the all-inclusive rate. RHCs and FQHCs do not bill for a visit when the only service involved is the administration of the hepatitis B vaccine.

Types of Bills for FIs

As required by CMS, there are nine specific bill types that are applicable for hepatitis B vaccination. The applicable bill types and associated revenue codes for hepatitis B vaccination are:

Table 6 – Facility Type, Type of Bill, and Revenue Codes for Hepatitis B Vaccination

Facility Type	Type of Bill	Revenue Codes
Hospital Outpatient	13X	0636 - vaccine 0771 - administration
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X	
SNF Outpatient	23X	
Home Health Agency	34X	
Renal Dialysis Facility (RDF)	72X	
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	
Critical Access Hospital (CAH)	85X	
Rural Health Clinic (RHC) (independent)	71X	052X
Federally Qualified Health Center (FQHC) (freestanding)	73X	

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. Also, CMS is eliminating the special HCPCS coding for independent and hospital-based FQHCs billed on TOB 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 0900/0910.

Special Billing Information

- No Legal Obligation to Pay – Non-governmental entities 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.

- RHCs and FQHCs - RHCs and Provider-based RHCs bill FIs using only bill type 71X. Providers-based FQHCs bill FIs using only bill types 71X (independent RHC) and 73X (freestanding FQHC), respectively. In addition, RHCs and FQHCs bill for hepatitis B vaccine using revenue code 052X.

❖ REIMBURSEMENT INFORMATION

General Information

Additional information about MPFS can be found at: www.cms.hhs.gov/physicians/pfs/ on the Web.

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at www.cms.hhs.gov/physicians/cciedits on the Web.

Reimbursement for the vaccine and its administration is paid at 80% of the MPFS. Deductible and coinsurance do apply. All providers that provide the hepatitis B vaccine must accept assignment even if the provider normally does not accept assignment as mandated by the Benefits Improvement and Protection Act of 2000 (BIPA), however it is not mandatory for providers to accept assignment for the *administration* of the vaccine.

Reimbursement of Claims by Fiscal Intermediaries (FIs)

The deductible and coinsurance do apply to the hepatitis B vaccine and its administration.

❖ REASONS FOR CLAIM DENIAL

The following are examples of situations where Medicare may deny coverage of hepatitis B vaccination:

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

- The beneficiary is not at intermediate or high risk of contracting hepatitis B.
- The services were not ordered by a doctor of medicine or osteopathy.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

❖ MASS IMMUNIZER ENROLLMENT PROCESS

A mass immunizer, as defined by CMS, is a provider who offers influenza and PPV 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. Often the influenza or PPV vaccinations are offered during an immunization program or clinic.

Providers and suppliers must enroll in Medicare even if mass immunizations are the only service they will provide to Medicare beneficiaries. Providers enroll by filling out Form CMS-855I for individuals or Form CMS-855B for a group. Simplified roster billing was developed to enable beneficiary participation in mass PPV and influenza virus vaccination programs offered by entities that bill Carriers; however **Medicare has not developed roster billing for Hepatitis B vaccinations**. Providers and suppliers who wish to roster bill for mass immunizations should contact the local Medicare Carrier servicing their area for a copy of the enrollment application and instructions for mass immunizers. A list of Carriers and their contact information can be found at: www.cms.hhs.gov/providers/enrollment/contacts on the Web.

Additional Information for Mass Immunizers

A mass immunizer may be a traditional Medicare physician, provider, or supplier such as a hospital outpatient department, or may be a nontraditional provider or supplier such as a senior citizen's center, public health clinic, community pharmacy, or supermarket.

An entity that enrolls with Medicare as a provider specialty type 73, Mass Immunization Roster Biller, must comply with the following:

- Only submit claims for influenza and PPV vaccines and their administration
- Submit claims for immunizations on roster bills
- Accept assignment on both the vaccine and its administration
- Submit claims only to Carriers

❖ ROSTER BILLING

Individuals and entities using roster billing to submit claims for PPV and influenza vaccinations must submit a separate preprinted 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. Providers should contact the Carrier for information regarding electronic billing/software.

Roster Billing Fiscal Intermediaries (FIs)

For Part A claims only, at least five beneficiaries must be vaccinated per day to roster bill. However, this requirement is waived for inpatient hospitals that mass immunize and use the roster billing method. Inpatient/outpatient departments of hospitals and outpatient departments of other providers may use a signature-on-file stamp or notation if they have access to a signature on file in the beneficiary's record.

Roster Billing Carriers

For Part B claims only, immunization of at least five beneficiaries on the same date is not required for any individual or entity to qualify for roster billing. However, the rosters may not be used for single patient bills, and the date of service for each vaccination must be entered.

The following information must be included on a patient roster form that will be attached to a pre-printed Form CMS-1500 under the simplified roster billing procedure:

- Patient Name and Address
- Health Insurance Claim Number
- Date of Birth
- Sex
- Date of Service
- Signature or stamped "Signature on File"
- Provider's Name and Identification Number

A signature-on-file stamp or notation qualifies as a signature on a roster claim form in cases where the provider has access to a signature on file in the beneficiary's record (e.g., when the vaccine is administered in a physician's office).

Other services may not be listed with the influenza vaccine/PPV 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. Other services must be billed using normal Medicare Part B claims filing procedures and forms.

In some instances, two entities, such as a grocery store and a pharmacy, jointly sponsor an influenza or PPV 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 that they did not furnish the vaccine. For roster billed claims, this can be accomplished by lining through the appropriate preprinted line item component that was not furnished by the billing entity or individual.

INFLUENZA, PNEUMOCOCCAL, AND HEPATITIS B VACCINATIONS

Resource Materials

Centers for Disease Control and Prevention www.cdc.gov

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.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information.
www.cms.hhs.gov/providers

Medicare Learning Network

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

Beneficiary Notices Initiative Website

www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information

www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website

www.cms.hhs.gov/physicians/cciedits

Medicare Preventive Services: Influenza and Pneumococcal Campaign

www.cms.hhs.gov/preventiveservices/2.asp

Immunizers' Question and Answer Guide to Medicare Coverage of Influenza and Pneumococcal Vaccinations

www.cms.hhs.gov/preventiveservices/2i.pdf

Medlearn Immunization Educational Resource Web Guide

www.cms.hhs.gov/medlearn/refimmu.asp

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.
www.wpc-edi.com/Codes/Codes.asp

Beneficiary-related resources can be found in Appendix C of this Guide.

BONE MASS MEASUREMENTS

❖ OVERVIEW

Osteoporosis is a disease in which bones become weak due to a decrease in bone mass coupled with a decrease in bone density. Osteoporosis produces an enlargement of the pore spaces in the bone, causing increased fragility and an increased risk for fracture. 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 two women and one in four 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, including 300,000 hip fractures and approximately 700,000 vertebral fractures, 250,000 wrist fractures, and more than 300,000 fractures at other sites.[13]

The Balanced Budget Act of 1997 (BBA) provided for standardization of Medicare coverage of bone density studies. This standardized coverage took effective for claims with dates of service on or after July 1, 1998. Medicare's bone mass measurement benefit includes a physician's interpretation of the results of the procedure.

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 photodensitometry, single or dual photon absorptiometry, or bone biopsy. 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. To ensure accurate measurement and consistent test results, bone density studies are to be performed on the same suitably precise instrument, and results must be obtained from the same scanner when comparing a patient to a control population.

Standardizing Bone Density Studies

To ensure accurate measurement and consistent test results, bone density studies should be performed on the same suitably precise instrument and results should be obtained from the same scanner when comparing a patient to a control population.

[13] National Institutes of Health and Related Bone Diseases - National Resource Center. 2004. *National Resource Center Fact Sheet, Osteoporosis Overview* [online]. Bethesda, MD: The National Institutes of Health and Related Bone Diseases - National Resource Center, National Institutes of Health, The U.S. Department of Health and Human Services, 2003 [cited 15 September 2004]. Available from the World Wide Web: (http://www.osteo.org/newfile.asp?doc=osteo&doctitle=Osteoporosis+Overview&doctype=HTML+Fact+Sheet).

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

Risk Factors

While anyone can develop osteoporosis, some factors that may put individuals at increased risk are included in the following list; however, Medicare does not cover all of these risk factors.

- 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
- Low-calcium diet

❖ COVERAGE INFORMATION

Medicare provides coverage of bone mass measurements every 2 years (i.e., at least 23 months have passed following the month in which the last Medicare-covered bone density study was performed) when performed on a qualified individual at clinical risk for osteoporosis. 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 7.5 mg of prednisone, or greater, per day, for more than 3 months.

- An individual with known primary hyperparathyroidism.

- An individual being monitored to assess the response to, or efficacy of, an FDA-approved osteoporosis drug therapy.

Who Is a Qualified Physician and Non-Physician Practitioner?

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.

Note: If medically necessary, Medicare may provide coverage for a beneficiary more frequently than every 2 years.

In addition, all of the following four sets of coverage criteria must be met:

- The individual's physician or qualified non physician practitioner treating the beneficiary must provide an order, following an evaluation of the need for a 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.

- The service must be furnished by a qualified supplier or provider of such services under the appropriate level of supervision by a physician.

- The service must be reasonable and necessary for diagnosing, treating, or monitoring an individual as defined above.

- 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 (DPA) or a bone sonometer (i.e., ultrasound) device approved or cleared for marketing by the FDA for bone density study purposes.

    - Is performed for the purpose of identifying bone mass, detecting bone loss, or determining bone quality.

    - Includes a physician's interpretation of the results of the procedure.

Coverage of bone mass measurements is provided 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
- X-ray/radiology with written interpretation

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 of more than 3 months

- Allowing for a confirmatory baseline bone density study (either central or peripheral) to permit future monitoring of a patient, if the initial test was performed with a different technique than the proposed monitoring method. For example, if the initial test was performed using bone sonometry, and monitoring is anticipated using bone densitometry, Medicare will allow coverage of a baseline measurement using bone densitometry.

❖ 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 photon absorptiometry (SPA), single energy X-ray absorptiometry (SEXA), dual energy X-ray absorptiometry (DEXA), quantitative computed tomography (QCT), and bone ultrasound densitometry (BUD).

Use the following Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes to report peripheral and central DEXA studies:

Table 1 – HCPCS/CPT Codes for Bone Mass Measurements

HCPCS/CPT Code	HCPCS/CPT Code Descriptor
HCPCS - G0130	Single Energy X-Ray Absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
CPT - 76070	Computed Tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
CPT - 76071	Computed Tomography bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
CPT - 76075	Dual Energy X-Ray Absorptiometry (DEXA) bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
CPT - 76076	Dual Energy X-Ray Absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
CPT - 76078	Radiographic Absorptiometry (Photodensitometry), one or more sites
CPT - 76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
CPT - 78350	Single Photon Absorptiometry bone density (bone mineral content) study, one or more sites

NOTE: Medicare does not pay for Dual Photon Absorptiometry (CPT 78351). This procedure is not reported under CPT codes 76075 or 76076.

Diagnosis Requirements

Contact the local Medicare Carrier or Fiscal Intermediary (FI) for specific diagnosis codes that are payable for bone mass measurements.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

❖ BILLING REQUIREMENTS

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS code (as listed in Table 1) and the appropriate diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS codes (as listed in Table 1), revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

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).

Types of Bills For FIs

The FI will reimburse for bone mass measurements when submitted on the following type of bills (TOB):

Table 2 – Facility Type, Type of Bills (TOB), and Revenue Codes for Bone Mass Measurements

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient (for Medicare Part B services)	12X	320
Hospital Outpatient	13X	
Hospital Outpatient - Other	14X	
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X	
SNF Outpatient	23X	
Home Health Agency (HHA)	34X	
Rural Health Clinic (RHC) (independent and provider-based)	71X	
Renal Dialysis Facility (RDF)	72X	
Federally Qualified Health Center (FQHC) (freestanding and provider-based)	73X	
Hospital Outpatient Surgery [subject to Ambulatory Surgical Center (ASC) Payment Limits]	83X	
Critical Access Hospital (CAH)	85X	

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. Also, CMS is eliminating the special HCPCS coding for independent and hospital-based FQHCs billed on TOB 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 0900/0910.

❖ REIMBURSEMENT INFORMATION

General Information

The Medicare Part B deductible and coinsurance apply.

Reimbursement of Claims by Carriers

Reimbursement for bone mass measurements is based 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: www.cms.hhs.gov/physicians/pfs/ on the Web.

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for bone mass measurements is based on the current payment methodologies for radiology services, and according to the type of provider.

❖ REASONS FOR CLAIM DENIAL

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 is not a qualified individual.
- Bone density studies of any type, including DEXA scans, are not covered under the portable X-ray benefit. The benefit allows X-ray films of the skeleton, chest, or abdomen. Although bone density studies are radiology procedures, they are not X-ray films. In addition, the portable X-ray service benefit requires that equipment be portable enough to provide services at home.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

BONE MASS MEASUREMENTS

Resource Materials

CMS Fact Sheet: Medicare Expands Coverage for Bone Density Measurements and Diabetes Self-Management

www.cms.hhs.gov/media/press/release.asp?Counter=341

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.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about the payment methodologies.
www.cms.hhs.gov/providers

Medicare Learning Network

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

Beneficiary Notices Initiative Website

www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information

www.cms.hhs.gov/contacts/incardir.asp

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.
www.wpc-edi.com/Codes/Codes.asp

Beneficiary-related resources can be found in Appendix C of this Guide.

GLAUCOMA SCREENING

❖ OVERVIEW

The American Academy of Ophthalmology defines glaucoma as a disease of the optic nerve. The eye is a closed structure; if the drainage area for the aqueous humor (called the drainage angle) is blocked, excess fluid cannot flow out of the eye. Fluid pressure within the eye increases, pushing against the optic nerve and causing damage. When damage to the optic nerve fibers occurs, blind spots develop. These blind spots usually go undetected until the optic nerve is significantly damaged. If the entire nerve is destroyed, blindness results.

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.

Glaucoma is a leading cause of irreversible blindness, affecting about 2.2 million Americans.[14] The disease often progresses silently (with no symptoms). Because of this silent progression, it is estimated that up to one-half of the approximately 2.2 million Americans with glaucoma may not know they have the disease.[15] Fortunately, if diagnosed and treated early, vision loss from glaucoma can be slowed or halted.

A glaucoma screening is defined to include:

- A dilated eye examination with an intraocular pressure (IOP) measurement.
  AND
- A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination.

In the past, it was thought that a high IOP measurement indicated glaucoma, and 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 high 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

Anyone may develop glaucoma; however Medicare provides coverage for beneficiaries in the following high risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and over

[14] Prevent Blindness America. 2004. Frequently Asked Questions About Glaucoma [online]. Schaumberg, IL: *Prevent Blindness America*, 2004 [cited 1 October 2004]. Available from the World Wide Web: (www.preventblindness.org/eye_problems/glaucoma_faq.html).

[15] Prevent Blindness America. 2004. Frequently Asked Questions About Glaucoma [online]. Schaumberg, IL: *Prevent Blindness America*, 2004 [cited 1 October 2004]. Available from the World Wide Web: (www.preventblindness.org/eye_problems/glaucoma_faq.html).

It is of special importance for African-Americans and those with diabetes to receive glaucoma screenings. According to the National Eye Institute (NEI), an African-American aged 45-64 is 15 times more likely to go blind from glaucoma than a Caucasian from the same age group.[16] Adults with diabetes are nearly twice as likely to develop glaucoma as other adults, and the longer a person has had diabetes, the more likely he or she is to develop glaucoma.[17]

❖ COVERAGE INFORMATION

Medicare pays for glaucoma screening annually (i.e., at least 11 months have passed following the month in which the last Medicare-covered glaucoma screening examination was performed) for eligible beneficiaries in at least one of the high risk groups.

Coverage of a screening glaucoma service is provided as a Medicare Part B benefit. The beneficiary will pay 20% (as the coinsurance or copayment) of the Medicare-approved amount, after meeting the yearly Medicare Part B deductible.

Medicare will pay for glaucoma screening examinations when they are furnished by or under the direct supervision in the office setting of an optometrist or ophthalmologist, legally authorized to perform the services under State law.

Who Are Qualified Physicians and Non Physician Practitioners?

Medicare will pay for glaucoma screening examinations where they are furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist, who is legally authorized to perform the services under State law.

❖ 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 IOP measurement *and* a direct ophthalmoscopic examination OR a slit-lamp biomicroscopic examination) was performed.

[16] The National Eye Institute. October 2004. *Don't Lose Sight of Glaucoma* [online]. Bethesda, MD: The National Eye Institute, The National Institutes of Health, The U.S. Department of Health and Human Services, 2004 [cited 1 October 2004]. Available from the World Wide Web: (www.nei.nih.gov/health/glaucoma/glaucoma_risk.asp).

[17] The National Eye Institute. June 2004. *Don't Lose Sight of Diabetic Eye Disease* [online]. Bethesda, MD: The National Eye Institute, The National Institutes of Health, The U.S. Department of Health and Human Services, 2004 [cited 1 October 2004]. Available from the World Wide Web: (www.nei.nih.gov/health/glaucoma/glaucoma_risk.asp).

❖ CODING AND DIAGNOSIS INFORMATION

Procedure Codes and Descriptors

Use the following Healthcare Common Procedure Coding System (HCPCS) codes to bill for glaucoma screening services:

Table 1 – HCPCS Codes for Glaucoma Screening Services

HCPCS Code	HCPCS Code Descriptor
G0117	Glaucoma screening for high risk patients furnished by an optometrist (physician for Carrier) or ophthalmologist
G0118	Glaucoma screening for high risk patients furnished under the direct supervision of an optometrist (physician for Carrier) or ophthalmologist

Additional Codes

The Carrier claims Type of Service (TOS) code to report with the HCPCS G codes is TOS Q.

Diagnosis Requirements

The beneficiary must be a member of one of the high risk groups mentioned to receive a Medicare-covered glaucoma screening. Providers bill for glaucoma screening using the screening ("V") diagnosis code of V80.1 (Special Screening for Neurological, Eye, and Ear Disease, Glaucoma).

❖ BILLING REQUIREMENTS

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS G code G0117 or G0118, and the corresponding diagnosis V code, must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS code G0117 or G0118, the appropriate revenue codes, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills For FIs

The FI will reimburse for glaucoma screenings when submitted on the following type of bills (TOB) and associated revenue codes:

Table 2 – Facility Type, Type of Bill, and Revenue Codes for Glaucoma Screening Services

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	096X, 097X, or 098X
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X	0770
SNF Outpatient	23X	0770
Rural Health Clinic (RHC) (independent and provider-based)	71X	0770 Use bill type 71X, revenue code 0770, HCPCS/CPT codes G0117 or G0118, and RHC revenue code 0521 to report the related visit. FIs will not make payment for revenue code 0770 unless the claim also includes visit revenue code 0521.
Federally Qualified Health Center (FQHC) (freestanding and provider-based)	73X	0770 Use bill type 73X, revenue code 0770, HCPCS/CPT codes G0117 or G0118, and FQHC revenue code 0520 to report the related visit. FIs will not make payment for revenue code 0770 unless the claim also includes visit revenue code 0520.
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0770
Critical Access Hospital (CAH)	85X	0770

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. Also, CMS is eliminating the special HCPCS coding for independent and hospital-based FQHCs billed on TOB 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 0900/0910.

Hospital outpatient departments are not required to report revenue code 0770; claims must be billed using any valid/appropriate revenue code.

❖ REIMBURSEMENT INFORMATION

General Information

Medicare Part B pays 80% of the Medicare-approved amount for the glaucoma screening (deductible and coinsurance apply).

Reimbursement of Claims by Carriers

Additional information about MPFS can be found at: www.cms.hhs.gov/physicians/pfs/ on the Web.

Additional information about OPPS can be found at: www.cms.hhs.gov/providers/hopps/ on the Web.

Reimbursement for glaucoma screening is based on the Medicare Physician Fee Schedule (MPFS). Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge. In some situations glaucoma screening codes are bundled with Evaluation and Management (E/M) codes. Additional information may be found at the National Correct Coding Initiative Edits website.

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for glaucoma screening is dependent upon the type of facility. For providers billing Outpatient Prospective Payment System (OPPS) claims, G0118 is bundled with G0117 if they are both billed on the same day. Additional information may be found at the National Correct Coding Initiative Edits Hospital OPPS website at www.cms.hhs.gov/providers/hopps/cciedits/ on the Web. These codes are not bundled for other providers billing FIs. 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)	Those that elect the optional method of payment for outpatient services	Sum of 80 percent of the CAH's reasonable costs of its outpatient services after application of the Medicare Part B deductible and coinsurance
	Those that do not elect the optional method of payment	Reasonable Cost Basis
Federally Qualified Health Center (FQHC) (freestanding and provider-based)		All-inclusive rate for the glaucoma screening based on the visit furnished to the patient.
Hospital Inpatient (for Medicare Part B Services)		Outpatient Prospective Payment System (OPPS)
Hospital Outpatient Department		OPPS
Rural Health Clinic (RHC) (independent and provider-based)		All-inclusive rate for the glaucoma screening based on the visit furnished to the patient.
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)		MPFS
SNF Outpatient Services		MPFS

❖ REASONS FOR CLAIM DENIAL

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.

To obtain Carrier and FI contact information please visit www.cms.hhs.gov/contacts/incardir.asp on the Web.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at www.wpc-edi.com/Codes/Codes.asp on the Web. Additional information about claims can be obtained from the Carrier or FI.

❖ WRITTEN ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

An Advance Beneficiary Notice (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.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit www.cms.hhs.gov/medicare/bni on the Web.

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.

GLAUCOMA SCREENING

Resource Materials

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.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about the OPPS.
www.cms.hhs.gov/providers

Medicare Learning Network

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

Medicare Program Memorandum for Carriers Transmittal B-01-46, Change Request 1717: Instructions for Billing for Claims for Screening Glaucoma Services

www.cms.hhs.gov/manuals/pm_trans/B0146.pdf

Medicare Program Memorandum for Intermediaries Transmittal A-01-105, Change Request 1783: Screening Glaucoma Services

www.cms.hhs.gov/manuals/pm_trans/A01105.pdf

Beneficiary Notices Initiative Website www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website www.cms.hhs.gov/physicians/cciedits

National Eye Institute www.nei.nih.gov/

The Medline Plus Health Information Website www.nlm.nih.gov/medlineplus

The Glaucoma Foundation Website www.glaucomafoundation.org

Prevent Blindness America Website www.preventblindness.org

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.
www.wpc-edi.com/Codes/Codes.asp

Beneficiary-related resources can be found in Appendix C of this Guide.

REFERENCE A: GLOSSARY

A

Abuse - A range of the following improper behaviors or billing practices including, but not limited to:

- Billing for a non-covered service;
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or
- Inappropriately allocating costs on a cost report

Accredited (Accreditation) - Means 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/URAC.

Act/Law/Statute - Term for legislation that passed through Congress and was signed by the President or passed over his 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.

Advance Beneficiary Notice (ABN) - Generally, an Advance Beneficiary Notice (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" (§1862(a)(1)); are "custodial care" (§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 (§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 who 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 Charge - Individual charge determined by a carrier for a covered SMI medical service or supply.

Ambulatory Surgical Center (ASC) - A place other than a hospital that does outpatient surgery. At an ambulatory (in and out) surgery center, you may stay for only a few hours or for one night.

American Academy of Ophthalmology (AAO) - The largest national membership association of ophthalmologists.

American Diabetes Association (ADA) - The nation's leading non-profit health organization providing diabetes research, information, and advocacy.

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 HIPAA-mandated electronic transaction format for Health Care Claims.

Approved Amount - 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 your 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.

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 in order to check for polyps or other abnormalities.

Beneficiary - The name for a person who has health insurance through the Medicare or Medicaid Program.

Bone Biopsy - A biopsy that involves the removal of a small piece of bone for examination.

Bone Density Studies (Bone Mass Measurements) - Tests 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 - When a group of services is listed under one code.

C

Cardiovascular Screening Blood Test - A new 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 private company that has a contract with Medicare to pay Medicare Part B bills

Centers for Medicare & Medicaid Services (CMS) - The HHS agency responsible for Medicare and parts of Medicaid. Centers for Medicare & Medicaid Services has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set. The division of the Department of Health and Human Services (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.

Certified - This means a hospital 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 - 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 X12 835 Claim Payment & Remittance Advice and the X12 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 (like 20%) - 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) - 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 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 your 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 HHS 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.

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 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 mother 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 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.

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 Center (Renal) - A hospital unit that is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of the ESRD dialysis patients (including inpatient dialysis) furnished directly or under arrangement.

Dialysis Facility (Renal) - A unit (hospital based or freestanding) which is approved to furnish dialysis services directly to ESRD patients.

Dietician/Nutritionist - A specialist in the study of nutrition.

Digital Rectal Exam - 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, allowing 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 can't 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 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.

Durable Medical Equipment Regional Carrier (DMERC) - A private company that contracts with Medicare to pay bills for durable medical equipment.

Durometer - Is a measure of surface resistivity or material hardness.

E

End Stage Renal Disease (ESRD) - Permanent kidney failure requiring dialysis or a kidney transplant.

Evaluation and Management (E/M) - A review of a beneficiary’s systems and/or past, family, or social history.

Electrocardiogram (EKG) - A graphical recording of the cardiac cycle produced by an electrocardiograph, an instrument used in the detection and diagnosis of heart abnormalities.

F

Fasting Plasma 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 - 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 government for a program to serve underserved areas and populations. Medicare pays for a full range of practitioner services (physician and 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 - 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-1450 - The uniform institutional claim form.
Form CMS-1500 - The uniform professional claim form.
Form CMS-855 - The form used to enroll in Medicare.

Fraud - The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

G

Global Component - When referencing billing/payment requirements, the combination of both the technical and professional components

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.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - A law passed in 1996 which is also sometimes called the "Kassebaum-Kennedy" law. This law expands your health care coverage if you have lost your job, or if you move from one job to another, HIPAA protects you and your family if you have: pre-existing medical conditions, and/or problems getting health coverage, and you think it is based on past or present health. HIPAA also:

- limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage;
- usually gives you credit for health coverage you have had in the past;
- may give you special help with group health coverage when you lose coverage or have a new dependent; and
- generally, guarantees your right to renew your health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.

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.

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 (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice - Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).

Hospice Care - A special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. 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.

Immunosuppressive Drugs - Transplant drugs used to reduce the risk of rejecting the new kidney after transplant. Transplant patients will need to take these drugs for the rest of their lives.

Infusion Pumps - Pumps for giving fluid or medication into your vein at a specific rate or over a set amount of time.

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.

Indian Health Service (IHS) - An agency within the DHHS responsible for providing federal health services to American Indians and Alaska Natives.

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 U.S. extension, maintained by the National Centers for Health Statistics (NCHS) within the CDC, identifies morbidity factors, or diagnoses. The ICD-9-CM codes have been selected for use in the 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 don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

Loop - A group of semantically related segments within an X12 electronic transaction.

M

Mass Immunization Center - A location where providers administer pneumococcal pneumonia and influenza virus vaccination and submit these services as electronic media claims, paper claims, or using 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 (4408.8, Part 3 of MCM).

Mass Immunizer - A provider who offers the influenza vaccine and the pneumococcal polysaccharide vaccine (PPV) to a large number of individuals (for example, the general public or members of a specific group, such as residents of a retirement community).

Medical Nutrition Therapy - Nutritional therapy covered by Medicare for beneficiaries diagnosed with diabetes or a renal disease.

Medicare Advantage - A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.

Medicare Carrier - A private company that contracts with Medicare to pay Part B bills.

Medicare Clinical Laboratory Fee Schedule - A complete listing of fees that Medicare uses to pay clinical laboratories.

Medicare Contractor - A Medicare Part A Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medicare Durable Medical Equipment Regional Carrier (DMERC)

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 Limiting Charge - The maximum amount a non-participating physician may legally charge a Medicare beneficiary for services billed on non-assigned claims.

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, and some medical services that are not covered by Part A.

Medicare Physician Fee Schedule - 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 of 2003 (MMA) - A comprehensive bill, signed by President George W. Bush on December 8, 2003, that expands many different phases of Medicare and introduces the Medicare-approved drug discount cards. The MMA also expanded the list of preventive services covered by Medicare.

Medicare Summary Notice - A notice the beneficiary gets after the doctor files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the

provider billed for, the Medicare-approved amount, how much Medicare paid, and what the beneficiary must pay.

N

National Supplier Clearinghouse (NSC) - The national entity contracted by CMS that issues DMEPOS supplier authorization numbers.

Non-assigned Claim - A type of claim that may only be filed by a non-participating Medicare physician. When a non-assigned claim is filed, the beneficiary is reimbursed directly.

Non-participating Physician - A doctor or supplier who does not accept assignment on all Medicare claims.

Non-physician Practitioner - A health care provider who meets state licensing requirements to provide specific medical services. Medicare allows payment for services furnished by non physician practitioners, including, but not limited to, advance 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 2 or more years of advanced training and has passed a special exam. 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 - Provide a range of splints, braces and special footwear to aid movement, correct deformity and relieve discomfort.

Outpatient Hospital Services - Medicare or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay, including:

- 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; and
- emergency room or outpatient clinic, including same day surgery; and
- X-rays and other radiation services.

P

Pap Test - A test to check for cancer of the cervix, the opening to a woman's womb. It is done by removing cells from the cervix. The cells are then prepared so they can be seen under a microscope.

Pedorthist - Is 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 exam to check if internal female organs are normal by feeling their shape and size.

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 or 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 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 non physician practitioner) and the signature of the physician (or qualified non physician practitioner) denoting any changes to the plan of care.

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 vaccinations.

Professional Component - 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 - Provide 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, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) 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, 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 CMS guidelines used by FIs and Carriers 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 - 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 ROs 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 Claim Adjustment Reason and Remark Codes - Codes used within the 835 Transaction to convey information about remittance processing or to provide a supplemental explanation for an adjustment.

Renal Dialysis Facility - 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 in Field Locator 42 of the UB-92 found in Medicare and/or NUBC (National Uniform Billing Committee) manuals (0401, 0403, etc.).

Roster Billing - A process developed by CMS that enables entities that accept assignment and administer the flu and/or PPV vaccine to multiple beneficiaries to bill Medicare for payment using a modified Form CMS-1450 or Form CMS-1500 claim form. Also referred to as simplified roster billing.

Rural Health Clinic - 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 U.S. 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 ninth edition of the International Classification of Diseases 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) - Method of bone mass measurement that measures the wrist or heel.

Single Proton Absorptiometry (SPA) - Method of bone mass measurement that measures the wrist.

Skilled Nursing Facility (SNF) - A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health 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 - 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, etc).

Type of Service (TOS) Code - A single alphabetic or numeric code that provides information about the type of service rendered (e.g., medical care, surgery, etc.). The TOS code is used in combination with the HCPCS CPT code.

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 Examination - A comprehensive initial preventive physical examination provided by Medicare in order to assess risk factors for disease. The "Welcome to Medicare" Physical Examination is available to all beneficiaries who begin their Medicare coverage on or after January 1, 2005, and must be provided within the first six months of coverage. It is the Initial Preventive Physical Exam (IPPE) or the “Welcome to Medicare” physical exam or visit.

World Health Organization - An organization that maintains the International Classification of Diseases (ICD) medical code set.

X

X12 - An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under HIPAA are X12 standards.

REFERENCE B: CMS AND MEDICARE WEBSITES

General Medicare Resources	
Name of Website	**Website Location Link**
CMS Acronym List	www.cms.hhs.gov/acronyms/default.asp
CMS Beneficiary Notices Initiative	www.cms.hhs.gov/medicare/bni/default.asp
CMS Carrier/Fiscal Intermediary Toll-Free Number Selection	www.cms.gov/medlearn/tollnums.asp
CMS Influenza/Pneumococcal Campaign	www.cms.hhs.gov/preventiveservices/2.asp
CMS Regional Flu Coordinators	www.cms.hhs.gov/medlearn/flu-coord.pdf
CMS Forms	www.cms.hhs.gov/forms www.cms.hhs.gov/providers/edi/edi5.asp
CMS Glossary	www.cms.hhs.gov/glossary
CMS Healthcare Common Procedural Coding System (HCPCS) Current Procedural Terminology (CPT)	www.cms.hhs.gov/medicare/hcpcs
CMS Home Page	www.cms.hhs.gov
CMS ICD-9-CM Coordination and Maintenance Committee	www.cms.hhs.gov/paymentsystems/icd9/default.asp
CMS Intermediary-Carrier Directory	www.cms.hhs.gov/contacts/incardir.asp
CMS Medicare Fee-for-Service Provider/Supplier Enrollment	www.cms.hhs.gov/providers/enrollment
CMS Medicare Modernization Update	www.cms.hhs.gov/mmu
CMS Medlearn	www.cms.hhs.gov/medlearn
CMS Online Manual System	www.cms.hhs.gov/manuals
CMS Preventive Services	www.cms.hhs.gov/preventiveservices
CMS Quality Initiatives	www.cms.hhs.gov/quality

General Medicare Resources	
Name of Website	**Website Location Link**
CMS Regional Offices - Information for Professionals	www.cms.hhs.gov/about/regions/professionals.asp
Fight Flu and Pneumonia	www.medicare.gov/health/fludetails.asp
Medicare.Gov Home Page	www.medicare.gov
Medicare and You 2005	www.medicare.gov/Publications/Pubs/pdf/10050.pdf
Medicare-Health Information Overview	www.medicare.gov/Health/Overview.asp
Medicare: Cervical Cancer Information	www.medicare.gov/health/cervical_info.asp
Medicare: Cervical Cancer Links	www.medicare.gov/Health/Cervical.asp
Medicare: Colorectal Cancer Awareness	www.medicare.gov/health/awareness.asp
Medicare: Colorectal Cancer Information	www.medicare.gov/Health/ColonCancer.asp
Medicare: Glaucoma Information	www.medicare.gov/health/glaucoma_info.asp
Medicare: Glaucoma Links	www.medicare.gov/Health/glaucoma.asp
Medicare: Mammography Links	www.medicare.gov/Health/Mammography.asp www.cms.hhs.gov/preventiveservices/1.asp
Medicare Preventive Benefits Outreach Materials for Providers	www.cms.hhs.gov/partnerships/tools/2005preventive/default.asp
MMA - Complete Text of H.R. 1	www.cms.hhs.gov/mmu/HR1/HR1.pdf
MMA Information	www.medicare.gov/MedicareReform
National Diabetes Eye Exam Program	www.cms.hhs.gov/preventiveservices/3a.asp

Health Insurance Portability and Accountability Act of 1996 (HIPAA)	
Name of Information Source	**Contact Information**
CMS Health Insurance Portability and Accountability Act of 1996 (HIPAA) website	www.cms.hhs.gov/hipaa
CMS HIPAA Experts - E-mail Address	AskHIPAA@cms.hhs.gov
Department of Health & Human Services HIPAA Administrative Simplification website	aspe.os.dhhs.gov
HIPAA Administrative Simplification Hotline	410-786-4232
The Strategic National Implementation Process (SNIP) website	www.wedi.org
Designed Standard Maintenance Organizations (DSMOs) website	www.hipaa-dsmo.org

Address and Phone Number References		
Resource	**Address**	**Contact Information**
Department of Health & Human Services/Office for Civil Rights	Office for Civil Rights Department of Health & Human Services 200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201	Toll free: 800-368-1019 Toll free TDD: 800-537-7697 E-mail: OCRMail@hhs.gov
Department of Health & Human Services/Office of Inspector General Hotline	Office of the Inspector General Department of Health & Human Services Attn: HOTLINE 330 Independence Ave., SW Washington, D.C. 20201	Toll free: 800-447-8477 Toll free TTY: 800-377-4950 Fax: 800-223-8164 E-mail: HHSTips@oig.dhhs.gov
Medicare Beneficiary Help Line	N/A	Toll free: 1-800-MEDICARE (800-633-4227) Toll free TTY/TDD: 1-877-486-2048

REFERENCE C: PREVENTIVE WEBSITES

The following websites and contact information may be useful to Medicare beneficiaries and providers interested in further information on preventive services, and certain diseases and conditions mentioned throughout this Guide.

Additional Resources	
Name of Resource	**Website Location Link**
Agency for Healthcare Research and Quality (AHRQ)	www.ahrq.gov
American Academy of Ophthalmology	www.aao.org
American Cancer Society	www.cancer.org
American Diabetes Association	www.diabetes.org
American Heart Association	www.americanheart.org
American Thoracic Society (ATS)	www.thoracic.org
CDC National Immunization Program	www.cdc.gov/nip
Centers for Disease Control and Prevention (CDC): Recommendations of the Advisory Committee on Immunization Practices (ACIP)	www.cdc.gov
Department of Health and Human Services	www.hhs.gov
Everyday Choices	www.everydaychoices.org
FDA Mammography	www.fda.gov/cdrh/mammography/index.html
FDA list of Mammography Facilities	www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm

Additional Resources	
Name of Resource	**Website Location Link**
Infectious Diseases Society of America (IDSA)	www.idsociety.org
MedQIC-Adult Immunization Project	www.medqic.com/content/nationalpriorities/topics/projectdes.jsp?topicID=471
MedQIC-National Pneumonia Project	www.nationalpneumonia.org/
National Cancer Institute	www.cancer.gov
National Cancer Institute: Breast Cancer: Screening & Testing	www.cancer.gov/cancerinfo/screening/breast
National Institutes of Health: National Eye Institute	www.nei.nih.gov
National Heart Lung and Blood Institute	www.nhlbi.nih.gov/
Osteoporosis and Related Bone Diseases	www.osteo.org
The US Preventive Services Task Force (USPSTF)	www.ahcpr.gov
Level I CPT Book Level II HCPCS Book ICD-9-CM Diagnosis Coding Book	Order online by visiting the American Medical Association Press Online Catalog at www.amapress.org on the Web Toll free: 800-621-8335
List of Claims Adjustment Reason and Remark Codes	www.wpc-edi.com
International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)	www.cdc.gov/nchs/about/otheract/icd9/abticd9.htm

Medicare Immunization Partners	
Name of Information Source	**Contact Information**
The Immunization Action Coalition (IAC)	www.immunize.org/catg.d/free.htm
The National Partnership for Immunization (NPI)	www.partnersforimmunization.org/links.html
The Association of Teachers of Preventive Medicine (ATPM)	www.atpm.org/
The National Coalition for Adult Immunization (NCAI)	www.nfid.org/ncai/
The National Foundation for Infectious Diseases (NFID)	www.nfid.org/
National Network for Immunization Information (NNII)	www.immunizationinfo.org/

Contact Information		
Resource	**Address**	**Direct Contact Information**
Department of Health & Human Services/Office for Civil Rights	Office for Civil Rights Department of Health & Human Services 200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201	Toll free: 800-368-1019 Toll free TDD: 800-537-7697 E-mail: OCRMail@hhs.gov
Medicare Beneficiary Help Line	N/A	Toll free: 1-800-MEDICARE (800-633-4227) Toll free TTY/TDD: 1-877-486-2048

REFERENCE D: PREVENTIVE BENEFITS CHART

❖ STAYING HEALTHY – MEDICARE'S PREVENTIVE SERVICES

An important way to stay healthy is to use preventive services provided by doctors and health care providers. Preventive services can find health problems early when treatment works best and can keep you from getting certain diseases or illnesses. Medicare pays for many preventive services to help keep you healthy. Talk to your doctor or health care provider to find out how often you need these services to stay healthy.

This chart is from the Beneficiary Guide to Preventive Services. Ordering information is found below.

Did you know that Medicare covers…	
One-time "Welcome to Medicare" Physical Examination	Beginning January 1, 2005, Medicare covers a one-time thorough review of your health, education and counseling about the preventive services you need, such as certain screenings and shots, and referrals for other care if you need it. You must have the physical examination within the first six months that you have Medicare Part B.
Cardiovascular Screenings	Beginning January 1, 2005, Medicare covers tests for cholesterol, lipid, and triglyceride levels. Check with your doctor to see if you qualify for these tests and how often Medicare will pay for them.
Screening Mammograms	These tests check for breast cancer before you or your doctor may be able to feel it. Medicare covers mammograms once every 12 months for all women with Medicare age 40 and older.
Pap Test and Pelvic Exam (includes clinical breast exam)	These exams check for cervical and vaginal cancers. Medicare covers these exams every 24 months for all women with Medicare and once every 12 months for women with Medicare at high risk.
Colorectal Cancer Screening	These tests help find colorectal cancer early, when treatment is most effective. Depending on your risk for developing cancer, one or more of the following tests is covered: Fecal Occult Blood Test, Flexible Sigmoidoscopy, Screening Colonoscopy, and/or Barium Enema. How often Medicare pays for these tests is different depending on the test you need and your level of risk for this cancer.

Did you know that Medicare covers…	
Prostate Cancer Screening	These tests help find prostate cancer. Medicare covers a digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months.
Flu Shots	These shots help prevent the influenza, or flu, virus. Medicare covers these shots once a year in the fall or winter for all people with Medicare.
Pneumococcal Shot	This shot helps prevent Pneumococcal infections. Medicare covers this shot for all people with Medicare. Most people only need this shot once in their lifetime.
Hepatitis B Shot	These three shots help protect people from getting Hepatitis B. Medicare covers these shots for people with Medicare at high or medium risk from Hepatitis B.
Bone Mass Measurements	These measurements help determine if you are at risk for broken bones. Medicare covers these measurements once every 24 months (more often if medically necessary) for people with Medicare at risk for osteoporosis.
Diabetes Screenings	Beginning January 1, 2005, Medicare covers tests to check for diabetes. Check with your doctor to see if you qualify for these tests and how often Medicare will cover them.
Glaucoma Tests	These tests help find the eye disease glaucoma. Medicare covers these tests once every 12 months for people with Medicare at high risk for glaucoma.

NOTE: For some of these services, you might have to pay a deductible, coinsurance, and/or copayment. These amounts vary depending on the type of services you need and the kind of Medicare health plan you have.

For more details about Medicare's coverage of these preventive services, including your costs in the Original Medicare Plan, get a free copy of the *Guide to Medicare's Preventive Services* (CMS Pub. No. 10110) at www.medicare.gov/ on the web. Select "Publications". Or, call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users should call 1-877-486-2048.