Medicare
Rural Health Clinic and Federally Qualified Health Centers Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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Refer to CHANGE REQUEST 2673

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NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2003*

Section 615 Magnetic Resonance Angiography (MRA), adds a new section providing coverage, billing, and payment instructions for MRA. Previously, Medicare provided limited coverage for MRA of the abdomen and chest. For claims with dates of service on or after July 1, 2003, Medicare coverage has been expanded for the use of MRA for diagnosing pathology in the renal or aortoiliac arteries.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CHAPTER VI
BILLING PROCEDURES

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614. BILLING OF PNEUMOCOCCAL PNEUMONIA, INFLUENZA VIRUS AND HEPATITIS B VACCINES BY RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

Part B of Medicare pays 100 percent for physician professional services under the Part B payment methodology. It also pays 100 percent of the reasonable cost for provider services for pneumococcal pneumonia vaccines (PPV), influenza virus vaccines, and its administration to a patient if it is ordered by a physician who is a doctor of medicine or osteopathy. Neither deductible nor coinsurance applies. Part B of Medicare also covers the reasonable cost for hepatitis B vaccine and its administration. Deductible and coinsurance apply for RHCs. For FQHCs, the deductible does not apply and coinsurance may be waived.

Effective for services furnished on or after September 1, 1984, hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B.

Effective for services furnished on or after May 1, 1993, influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law. Typically, this vaccine is administered once a year in the fall or winter. 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.

In order to provide for minimum disruption to the billing system, follow the procedures below:

- Do not include any charges for PPV or influenza virus vaccine administration on Form HCFA-1450;

- Count visits as under current procedures, except do not count or bill for visits when the only service involved is the administration of PPV and influenza virus; and

- Payment for PPV and influenza virus vaccine and their administration is made at the time of cost settlement, and intermediaries may adjust interim rates to account for this additional cost if they determine that the payment is more than a negligible amount.

RHCs and FQHCs bill for the hepatitis B vaccine just as any other RHC/FQHC service, using revenue code 52X (freestanding clinic). Payment for the vaccine is included in the all inclusive rate.

615. MAGNETIC RESONANCE ANGIOGRAPHY (MRA)

Section 1861(s)(2)(C) of the Social Security Act provides for coverage of diagnostic testing. Coverage of magnetic resonance angiography (MRA) of the head and neck, and MRA of the peripheral vessels of the lower extremities is limited as described in Medicare Coverage Issues Manual §50-14. This instruction has been revised as of July 1, 2003 based on a determination that coverage is reasonable and necessary in additional circumstances. Under that instruction, MRA is generally covered only to the extent that it is used as a substitute for contrast angiography, except to the extent that there are documented circumstances consistent with that instruction that demonstrate the medical necessity of both tests. There is no coverage of MRA outside of the indications and circumstances described in that instruction.

For claims with dates of service on or after July 1, 1999, Medicare provides limited coverage for MRA of the abdomen and chest as described in the Medicare Coverage Issues Manual.

For claims with dates of service on or after July 1, 2003, MRA coverage has been expanded to include imaging the renal arteries and the aortoiliac arteries in the absence of abdominal aortic aneurysm or aortic dissection. MRA should be obtained in those circumstances in which using MRA is expected to avoid obtaining contrast angiography (CA), when physician history, physical examination and standard assessment tools provide insufficient information for patient management, and obtaining an MRA has a high probability of positively affecting patient management. However, CA may be ordered after obtaining the results of an MRA in those rare instances where medical necessity is demonstrated.

Bill on Form HCFA-1450 or electronic equivalent.

Applicable Bill Types. – The appropriate bill types are 71X and 73X.

When utilizing the UB-92 flat file use record type 40 to report bill type. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), and type of bill (Field No. 4) are required.

When utilizing the hard copy UB-92 (Form HCFA-1450), report the applicable bill type in Form Locator (FL) 4 "Type of Bill".

When utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the applicable bill type in 2-130-CLM01, CLM05-01, and CLM05-03.

HCPCS Code Reporting. – The following HCPCS codes should be used to report these services:

MRA of head	70544, 70544-26, 70544-TC
MRA of head	70545, 70545-26, 70545-TC
MRA of head	70546, 70546-26, 70546-TC
MRA of neck	70547, 70547-26, 70547-TC
MRA of neck	70548, 70548-26, 70548-TC
MRA of neck	70549, 70549-26, 70549-TC
MRA of chest	71555, 71555-26, 71555-TC
MRA of abdomen	74185, 74185-26, 74185-TC
MRA of peripheral vessels of lower extremities	73725, 73724-26, 73724-TC

For claims with dates of service on or after July 1, 2003, coverage under this benefit has been expanded for the use of MRA for diagnosing pathology in the renal or aortoiliac arteries. The following HCPCS code should be used to report this expanded coverage of MRA:

MRA, pelvis, with or without contrast material(s)	72198

When utilizing the UB-92 flat file, use record type 61, HCPCS code (Field No. 6) to report HCPCS/CPT code. When utilizing the hard copy UB-92, report the HCPCS/CPT code in FL 44 "HCPCS/Rates." When utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the HCPCS/CPT in 2-395-SV202-02.

Special Billing Instructions

Independent RHCs and free-standing FQHCs bill under bill type 71X and 73X for the professional component utilizing revenue codes 520 and 521 as appropriate. HCPCS coding is not required. The technical component is outside the scope of the RHC/FQHC benefit. The provider of the technical service bills on Form CMS-1500 or electronic equivalent to the carrier.

The technical component for a provider based RHC/FQHC is typically furnished by the provider. The provider of that service bills under bill type, 13X, 14X 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.)

Payment Requirements

Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs) – All inclusive rate, professional component only, based on the visit furnished to the RHC/FQHC beneficiary to receive the MRA. The technical component is outside the scope of the RHC/FQHC benefit. Therefore the provider of the technical service bill their carrier on Form CMS-1500 and payment is made under MPFS.

Deductible and coinsurance apply.