Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2673

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

Section 3665 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.

These instructions should be implemented within your current operating budget.

CHAPTER VII
BILL REVIEW

Physician Services

Section

Cost Reimbursement Providers

3665. Magnetic Resonance Angiography.—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.

Follow the general bill review instruction in §3604. Providers bill you on Form HCFA-1450 or electronic equivalent.

Applicable Bill Types. – The appropriate bill types are 11X, 12X, 13X, 14X, 71X, 73X and 85X.

Providers 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.

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

Providers 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, 73725-26, 73725-TC

Hospitals subject to OPPS should report the following C codes in place of the above HCPCS codes as follows:

MRA of chest	71555:	C8909 – C8911
MRA of abdomen	74185:	C8900 – C8902
MRA of peripheral vessels of lower extremities	73725:	C8912 – C8914

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, 72198-26, 72198-TC

Hospitals subject to OPPS report the following C codes in place of HCPCS code 72198:

MRA, pelvis, with or without contrast material(s) 72198: C8918 - C8920

Providers utilizing the UB-92 flat file, use record type 61, HCPCS code (Field No. 6) to report HCPCS/CPT code. Providers utilizing the hard copy UB-92, report the HCPCS/CPT code in FL 44 "HCPCS/Rates." Providers 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 for RHCs and FQHCs

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

Payment is as follows:

Inpatient – PPS, based on the DRG

Hospital outpatient departments – OPPS, based on the APC

Critical Access Hospital (CAH) – For CAHs that elected the optional method of payment for outpatient services, the payment for technical services would be the same as the CAHs that did not elect the optional method.-Reasonable cost. However, you would pay the professional component at 115 percent of Medicare Physician Fee Schedule (MPFS).

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.