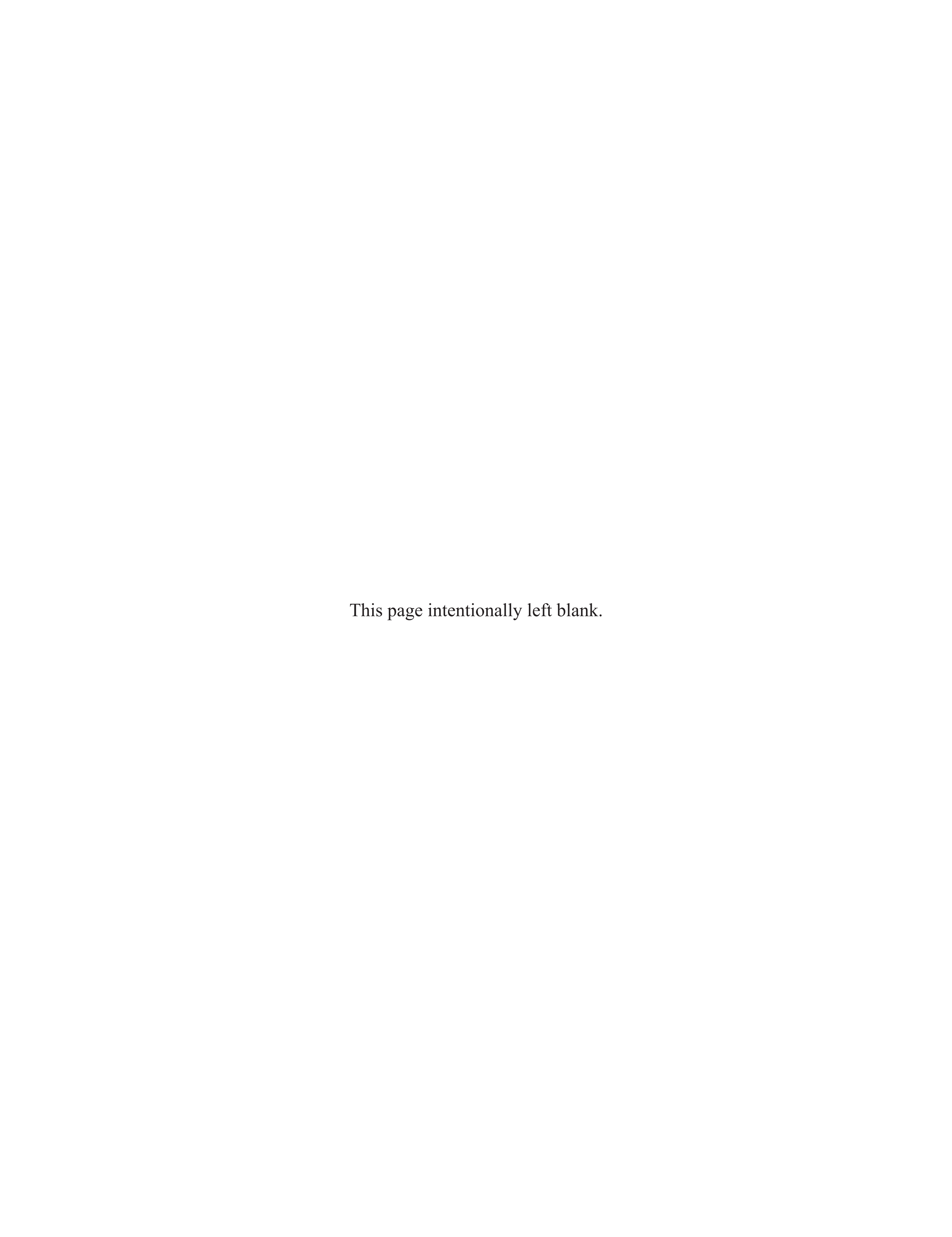
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

The Guide to

ICN 006439 March 2011

Fourth Edition



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The Guide to Medicare Preventive Services

Fourth Edition

March 2011

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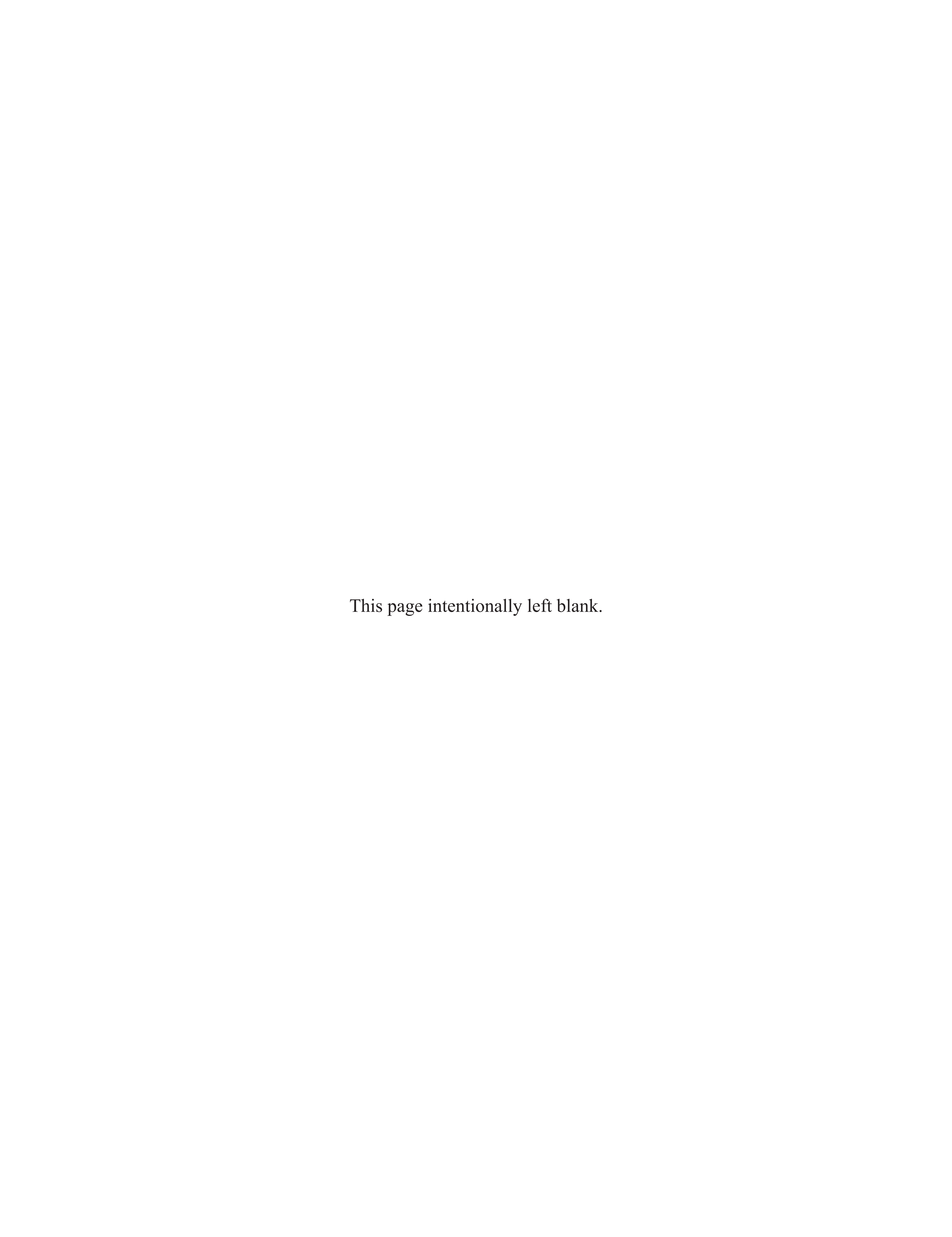

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Preface

Welcome to the fourth edition of The Guide to Medicare Preventive Services, formerly titled "The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals."

With the release of the fourth edition of this Guide, the Centers for Medicare & Medicaid Services (CMS) continues its initiative to educate the provider community and Medicare beneficiaries about the preventive benefits covered by Medicare. An important part of this initiative includes motivating Medicare beneficiaries to help maintain a healthy lifestyle by making the most of Medicare-covered preventive services.

The passage of the Affordable Care Act made a number of improvements to Medicare coverage of preventive services, including removing barriers to preventive care by eliminating beneficiary copayments and deductibles on many preventive services, as well as providing coverage of new benefits such as an Annual Wellness Visit (AWV) and Human Immunodeficiency Virus (HIV) screening. Now, more than ever, preventive services are more affordable and accessible to Medicare beneficiaries.

CMS recognizes the crucial role that health care providers play in providing and educating Medicare beneficiaries about potentially life-saving preventive services and screenings. While Medicare pays for many preventive benefits, many Medicare beneficiaries do not fully realize that using preventive services and screenings can help them live longer, healthier lives. As a health care professional, you can help your Medicare patients understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life. The information found in this Guide can help you communicate with your patients about Medicare-covered preventive benefits, as well as assist you in correctly billing for these services.

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

- Initial Preventive Physical Examination (IPPE);
- Ultrasound Screening for Abdominal Aortic Aneurysms (AAAs);
- Cardiovascular Screening Blood Tests;
- Annual Wellness Visit (AWV) – New benefit for 2011!;
- Seasonal Influenza, Pneumococcal, and Hepatitis B Vaccinations;
- Diabetes-Related Services;
- Glaucoma Screening;
- Screening Mammography;
- Screening Pap Tests;
- Screening Pelvic Examination;
- Colorectal Cancer Screening;
- Prostate Cancer Screening;
- Human Immunodeficiency Virus (HIV) Screening – New!;
- Bone Mass Measurements; and
- Tobacco-Use Cessation Counseling Services.

Additional Educational Resources

In addition to this publication, CMS created a variety of complementary preventive services-related resources, such as brochures and quick reference information charts. You can order many of these products, free of charge, from the Medicare Learning Network® (MLN) by visiting http://www.cms.gov/MLNProducts on the CMS website and clicking on the Product Ordering Page in the related links section.

For more preventive services product information, including links to downloadable versions of our products, as well as web-based training courses, visit the MLN Preventive Services Educational Products web page located at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp on the CMS website.

We hope that you will find the fourth edition of The Guide to Medicare Preventive Services to be a useful tool that supports you and your staff in the delivery of quality preventive health care to people with Medicare. Thank you for partnering with CMS as we strive to increase awareness of preventive health care and educate health care professionals and beneficiaries about preventive benefits covered by Medicare.

Chapter 1
Initial Preventive Physical Examination

Overview

Medicare covers a one-time Initial Preventive Physical Examination (IPPE), also referred to as the "Welcome to Medicare" visit. The goals of this benefit are health promotion and disease detection and include education, counseling, and referral for other screening and preventive services also covered under Medicare Part B.

NOTE: For more information on the Annual Wellness Visit (AWV) benefit, effective for dates of service on or after January 1, 2011, refer to Chapter 4 of this Guide.

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible for the IPPE only are waived under the Affordable Care Act. Neither is waived for the screening electrocardiogram (EKG).

Important Reminders

1. The IPPE is a unique benefit available only for beneficiaries **new** to the Medicare Program and **must** be received within the first 12 months of the effective date of their Medicare Part B coverage.
2. This exam is a preventive visit and **not** a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare Part B does not provide coverage for routine physical exams.
3. 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.

Seven Components of the IPPE

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

Preparing Beneficiaries for the IPPE

Providers can help beneficiaries get ready for the IPPE by encouraging them to come prepared with the following information:

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

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

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

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

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

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

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

- Hearing impairment,
- Activities of daily living,
- Falls risk, and
- Home safety.

Component 4 - An examination

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

Component 5 - End-of-life planning

The IPPE includes end-of-life planning as a required service, upon the beneficiary's consent. End-of-life planning is verbal or written information provided to the beneficiary regarding:

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

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

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

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

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

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

- Bone mass measurements;
- Cardiovascular screening blood tests;
- Colorectal cancer screening tests;
- Diabetes screening tests;
- Diabetes outpatient self-management training services;
- Medical nutrition therapy for individuals with diabetes or renal disease;
- Pneumococcal, influenza, and hepatitis B vaccines and their administration;
- Prostate cancer screening tests;
- Screening for glaucoma;
- Screening for Human Immunodeficiency Virus (HIV) for high risk individuals;
- Screening mammography;
- Screening Pap test and screening pelvic examinations;
- Smoking and tobacco-use cessation counseling for asymptomatic individuals; and
- Ultrasound screening for abdominal aortic aneurysms.

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

NOTE: For dates of service on or after January 1, 2009, the screening EKG is no longer a required part of the IPPE. It may be performed as a result of a referral from an IPPE. The screening EKG will be allowed **only once** in a beneficiary's lifetime.

Coverage Information

Medicare provides coverage of the IPPE for beneficiaries **new** to the Medicare Program. The IPPE is a preventive physical examination and is **not** a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. **Medicare Part B does not provide coverage for routine physical examinations.** Medicare provides coverage of the IPPE for all **newly** enrolled beneficiaries who receive the IPPE within the first 12 months after the effective date of their Medicare Part B coverage. The IPPE is covered only as a **one-time** benefit per Medicare Part B enrollee.

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

Who Are Physicians and Qualified Non-Physician Practitioners?

Physician

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

Qualified Non-Physician Practitioner

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

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

Medicare provides coverage for the IPPE as a Medicare Part B benefit. For dates of service on or after January 1, 2009, the Medicare Part B deductible is waived for the IPPE only. The deductible is not waived for the screening EKG for services furnished prior to January 1, 2011. For dates of service on or after January 1, 2011, both the coinsurance or copayment and the Medicare Part B deductible are waived for the IPPE only. Neither is waived for the screening EKG.

Documentation

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

If a significant, 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. Refer to the "Documentation Guidelines for Evaluation and Management Services" for 1995 and 1997 at http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp on the Centers for Medicare & Medicaid Services (CMS) website for recording the appropriate clinical information in the beneficiary's medical record. Include all referrals and a written medical plan in this documentation.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) codes, listed in Table 1, must be used to report the IPPE and screening EKG services.

Table 1 – HCPCS Codes for the IPPE and Screening EKG

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

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

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

Diagnosis Requirements

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

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS G-code for the IPPE and screening EKG in the X12 837 Professional electronic claim format.

NOTE: In those cases where a Medicare provider qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Medicare will reimburse physicians or qualified non-physician practitioners for only **one** IPPE performed no later than 12 months after the date the beneficiary's first Medicare Part B coverage begins.

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

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

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

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

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS G-codes and the appropriate revenue code in the X12 837 Institutional electronic claim format. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) must report the HCPCS code for the IPPE to avoid application of the deductible (on RHC claims); assure payment for this service in addition to another encounter on the same day if they are both separate, unrelated, and appropriate; and update the Common Working File (CWF) record to track this once-in-a-lifetime benefit.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

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

Types of Bill (TOBs) for FIs/AB MACs

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

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Table 2 – Facility Types and TOBs for the IPPE and Screening EKG

Facility Type	Type of Bill
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X
Hospital Outpatient	13X
Skilled Nursing Facility (SNF) Inpatient Part B	22X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	77X
CAH Outpatient*	85X

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

Medicare pays only Method II CAHs for the professional component of the IPPE (HCPCS code G0402) itself (in addition to the facility payment) in revenue code 0960. If a Method II CAH performs the screening EKG, Medicare may also pay for the interpretation of the EKG (in addition to the payment for the tracing) when billed on TOBs 71X, 77X, and 85X (CAH Method II) in revenue codes 0985 or 0986.

Additional Billing Instructions for RHCs and FQHCs

- RHCs and FQHCs should follow normal billing procedures for RHC/FQHC services.
- Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at the same location constitute a single visit. In rare circumstances, an RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the IPPE when they are performed on the same day, when the encounters are separate, unrelated, and appropriate.
- The technical component of the EKG performed at an independent RHC/FQHC is billed to the carrier/AB MAC. For RHCs and FQHCs, there is no separate payment for the professional component of the EKG and no separate billing of it.
- RHCs and FQHCs use revenue code 052X. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520.
- The professional portion of the service billed to the FI/AB MAC on TOBs 71X or 77X should be made using the appropriate site of service revenue code in the 052X series and must include the HCPCS code.

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

Reimbursement Information

General Information

Medicare provides coverage for the IPPE as a Medicare Part B benefit. For dates of service on or after January 1, 2009, the Medicare Part B deductible is waived for the IPPE only. The deductible is not waived for the screening EKG. For dates of service on or after January 1, 2011, both the coinsurance or copayment and the Medicare Part B deductible are waived for the IPPE only. Neither is waived for the screening EKG.

Medicare pays for the HCPCS codes for the IPPE and screening EKG under the Medicare Physician Fee Schedule (MPFS).

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses the IPPE under the MPFS.

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all IPPE services.

Medicare Physician Fee Schedule (MPFS) Information

For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the IPPE depends on the type of facility providing the service. Table 3 lists the type of payment that facilities receive for the IPPE.

Table 3 – Facility Payment Methodology for the IPPE

Facility Type	Basis of Payment
Hospital Outpatient*	Outpatient Prospective Payment System (OPPS); hospitals not subject to OPPS are paid under current methodologies
Skilled Nursing Facility (SNF)	For services billed by SNFs on the 22X, payment for the technical component of the screening EKG is based on the Medicare Physician Fee Schedule (MPFS). FIs/AB MACs will pay for code G0402 for the IPPE and code G0404 for the screening EKG, tracing only when those services are submitted on a TOB 12X or 13X for hospitals subject to the OPPS.
Rural Health Clinic (RHC)**	All-Inclusive Encounter Rate
Federally Qualified Health Center (FQHC)**	All-Inclusive Encounter Rate
Critical Access Hospital (CAH)	Reasonable Cost

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

Outpatient Prospective Payment System (OPPS) Information

For more information about OPPS, visit http://www.cms.gov/HospitalOutpatientPPS on the CMS website.

****NOTE:** For RHCs and FQHCs, no separate payment for the screening EKG is made and no separate billing of it is required. The IPPE is the only HCPCS code separately reported. For dates of service on or after January 1, 2011, detailed HCPCS coding is required in FQHCs for all services.

Reasons for Claim Denial

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

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

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Initial Preventive Physical Examination

Resources

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

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

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

Medicare Learning Network® (MLN) “Medicare Preventive Services Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination” (ICN 006904)
http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

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

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

USPSTF Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.uspreventiveservicestaskforce.org/recommendations.htm

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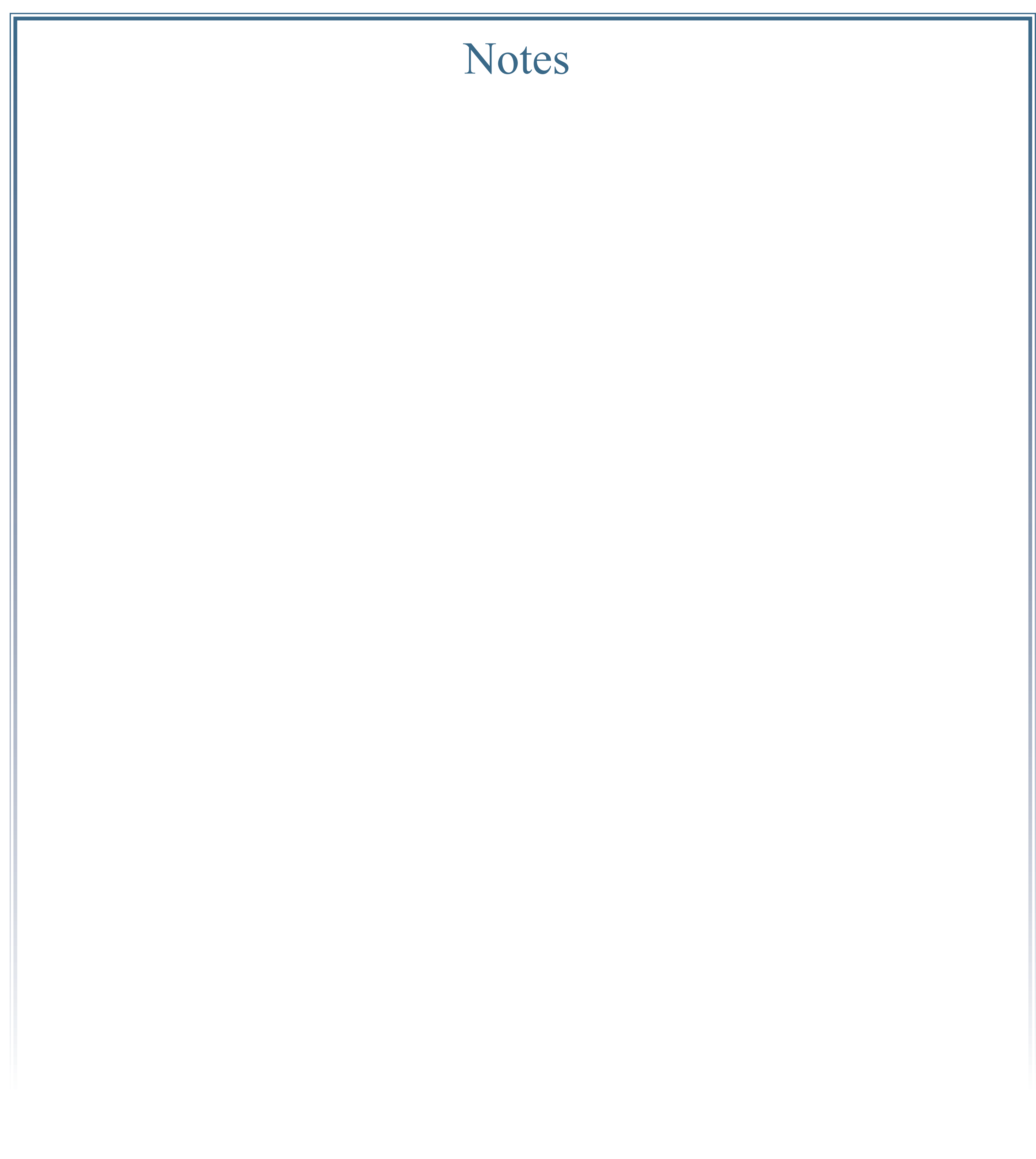
More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes



Notes

Chapter 2
Ultrasound Screening for Abdominal Aortic Aneurysms

Overview

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

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

Medicare coverage of a one-time preventive ultrasound screening for the early detection of AAAs for at-risk beneficiaries began for dates of service on or after January 1, 2007, when the service results from a referral from an Initial Preventive Physical Examination (IPPE).

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible for ultrasound screening for Abdominal Aortic Aneurysm (AAA) are waived under the Affordable Care Act.

Ultrasound Screening for AAAs

Ultrasound screening for AAA is a procedure that:

- Uses sound waves (or other procedures using alternative technologies, of commensurate accuracy and cost, as specified by the Centers for Medicare & Medicaid Services [CMS] through the national coverage determination process) provided for the early detection of AAA; and
- Includes a physician's interpretation of the results of the procedure.

Risk Factors

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

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

Coverage Information

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

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

Important Note

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

Medicare provides coverage for the ultrasound screening for AAA as a Medicare Part B benefit. The coinsurance or copayment applies to this benefit. The Medicare Part B deductible is waived. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

NOTE: The Medicare Part B deductible does not apply to Federally Qualified Health Center (FQHC) services.

Documentation

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

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) code, listed in Table 1, must be used to report the ultrasound screening for AAA.

Table 1 – HCPCS Code for Ultrasound Screening for AAA

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

Diagnosis Requirements

Medicare providers must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening ("V") diagnosis codes, listed in Table 2, for ultrasound screening for AAA.

Table 2 – Diagnosis Codes for Ultrasound Screening for AAA

ICD-9-CM Diagnosis Code	Code Descriptor
V15.82	Personal history of tobacco use presenting hazards to health
V17.4	Family history of other cardiovascular disease
V81.2	Special screening for other and unspecified cardiovascular conditions

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report HCPCS code G0389 and the corresponding ICD-9-CM diagnosis code in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report HCPCS code G0389, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for the ultrasound screening for AAA when submitted on the following TOBs and associated revenue codes, listed in Table 3.

Table 3 – Facility Types, TOBs, and Revenue Codes for Ultrasound Screening for AAA

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X	040X
Hospital Outpatient	13X	040X
Skilled Nursing Facility (SNF) Inpatient Part B*	22X	040X
SNF Outpatient	23X	040X
Rural Health Clinic (RHC)	71X	052X See Additional Billing Instructions for RHCs and FQHCs
Federally Qualified Health Center (FQHC)	77X	052X See Additional Billing Instructions for RHCs and FQHCs
CAH**	85X	040X
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12X, 13X	040X
Indian Health Service (IHS) Inpatient Part B including CAH	12X	024X
IHS CAH	85X	051X

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for ultrasound screening for AAA for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Ultrasound screening for AAA provided by other facility types must be reimbursed by the SNF.

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

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

Additional Billing Instructions for RHCs and FQHCs

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

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

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

- **Technical Component** for Provider-Based RHCs and FQHCs:
  - The base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **Technical Component** for Independent RHCs and FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component for Dates of Service Prior to January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a physician or qualified non-physician practitioner furnishes an ultrasound screening for AAA within an RHC/FQHC, the screening is considered an RHC/FQHC service. The provider of an ultrasound screening for AAA service must bill the FI/AB MAC under TOB 71X or 77X, respectively. The professional portion of the service is billed to the FI/AB MAC using revenue code 052X and HCPCS code G0389.
- **Professional Component for Dates of Service on or After January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - Detailed HCPCS coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The RHC/FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment (and deductible for RHCs). An additional line with revenue code 052X should be submitted with the appropriate HCPCS code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive encounter rate, and coinsurance or copayment and deductible will not apply.
  - If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/Current Procedural Terminology (CPT) code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.

Reimbursement Information

General Information

Medicare provides coverage of ultrasound screening for AAA as a Medicare Part B benefit. For dates of service prior to January 1, 2010, the coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

NOTE: The Medicare Part B deductible does not apply to FQHC services.

Reimbursement of Claims by Carriers/AB MACs

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

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all ultrasound screening for AAA services.

Medicare Physician Fee Schedule (MPFS) Information

For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the ultrasound screening for AAA depends on the type of facility providing the service. Table 4 lists the type of payment that facilities receive for the ultrasound screening for AAA.

Table 4 – Facility Payment Methodology for Ultrasound Screening for AAA

Facility Type	Basis of Payment
Hospital subject to the Outpatient Prospective Payment System (OPPS)	OPPS
Critical Access Hospital (CAH)	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of Medicare Physician Fee Schedule (MPFS) non-facility rate for professional component(s) of services
Indian Health Service (IHS) Provider – Outpatient	Office of Management & Budget (OMB)-Approved Outpatient Per Visit All-Inclusive Rate (AIR)
IHS Provider – Hospital Inpatient Part B	All-Inclusive Inpatient Ancillary Per Diem Rate
IHS CAH	101% of the All-Inclusive Facility Specific Per Visit Rate
IHS CAH – Hospital Inpatient Part B	101% of the All-Inclusive Facility Specific Per Diem Rate
Skilled Nursing Facility (SNF)*	MPFS non-facility rate
Rural Health Clinic (RHC)	All-Inclusive Encounter Rate
Federally Qualified Health Center (FQHC)	All-Inclusive Encounter Rate
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	94% of provider submitted charges or according to the terms of the Maryland Waiver

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for ultrasound screening for AAA for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Ultrasound screening for AAA services provided by other facility types must be reimbursed by the SNF.

Outpatient Prospective Payment System (OPPS) Information

For more information about OPPS, visit http://www.cms.gov/HospitalOutpatientPPS on the CMS website.

Reasons for Claim Denial

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

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

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Ultrasound Screening for Abdominal Aortic Aneurysms

Resources

CMS AAA Web Page
http://www.cms.gov/AAAScreen

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

Medicare Learning Network® (MLN) Preventive Services Educational Products Website
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

Society of Thoracic Surgeons
http://www.sts.org

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

USPSTF Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations on screening for AAA.
http://www.uspreventiveservicestaskforce.org/uspstf/uspsaneu.htm

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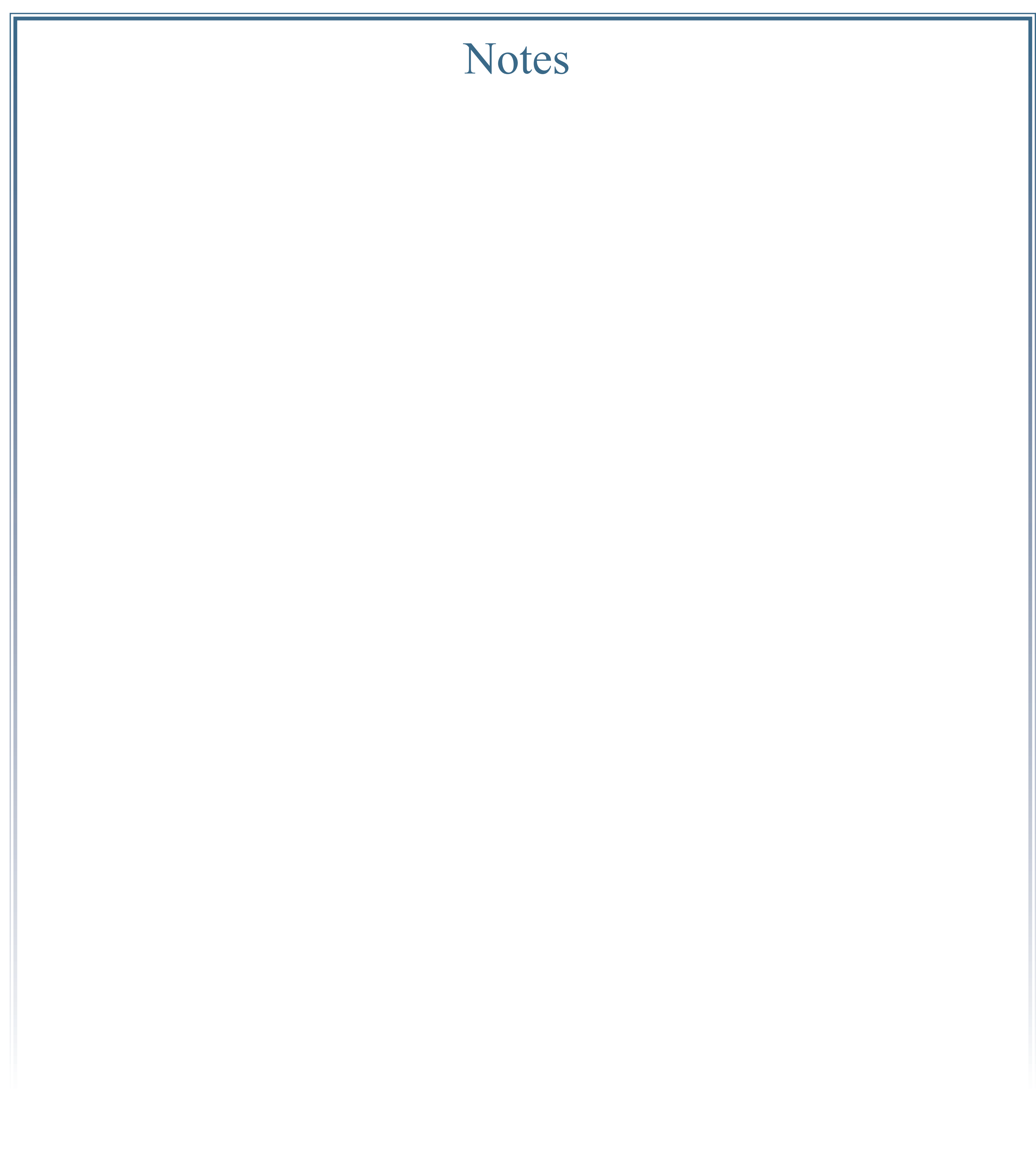
More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes



Notes

Chapter 3
Cardiovascular Screening Blood Tests

Overview

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

Medicare coverage of cardiovascular screening blood tests began for dates of service on or after January 1, 2005, for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke. These tests can help determine a beneficiary's cholesterol and other blood lipid levels such as triglycerides. The Centers for Medicare & Medicaid Services (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 include the following:

- Total Cholesterol Test,
- Cholesterol Test for High Density Lipoproteins, and
- Triglycerides Test.

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

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

The coinsurance or copayment and deductible for cardiovascular screening blood tests were already waived and are not affected by the Affordable Care Act.

The Affordable Care Act revised the list of preventive care services paid by Medicare in the Federally Qualified Health Center (FQHC) setting. For dates of service on or after January 1, 2011, the professional component of cardiovascular screening blood tests is a covered FQHC service when provided by an FQHC.

Risk Factors

The coverage of cardiovascular screening blood tests presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing heart disease and how they can control their cholesterol levels through diet, physical activity, or medication, if necessary. Cardiovascular disease can develop in anyone; however, risk factors for developing cardiovascular disease include the following:

- Diabetes;
- Family history of cardiovascular disease;
- Diets high in saturated fats, cholesterol, and salt or sodium;
- History of previous heart disease;
- Hypercholesterolemia (high cholesterol);

- Hypertension;
- Lack of exercise;
- Obesity;
- Excessive alcohol use;
- Smoking; and
- Stress.

Coverage Information

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

Who Are Physicians and Qualified Non-Physician Practitioners?

Physician

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

Qualified Non-Physician Practitioner

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

Calculating Frequency

When calculating frequency to determine the 59-month period, the count starts beginning with the month after the month in which a previous test was performed.

EXAMPLE: The beneficiary received a cardiovascular screening blood test in January 2010. The count started beginning February 2010. The beneficiary will be eligible to receive another cardiovascular screening blood test in January 2015 (the month after 59 months have passed).

Coinsurance or Copayment and Deductible

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

Stand Alone Benefit

The cardiovascular screening blood tests benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

Documentation

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

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Current Procedural Terminology (CPT) codes, listed in Table 1, must be used to report the cardiovascular screening blood tests.

Table 1 – CPT Codes for Cardiovascular Screening Blood Tests

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

NOTE: The above tests should be ordered as a lipid panel; however, they may be ordered individually. To ensure that Medicare and Medicaid only pay for a laboratory test categorized as waived complexity under the Clinical Laboratory Improvement Amendments (CLIA), these CPT codes must be billed with modifier -QW to be recognized as a waived test.

Diagnosis Requirements

Medicare providers must report one or more of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening (“V”) diagnosis code(s), listed in Table 2, for cardiovascular screening blood tests.

Table 2 – Diagnosis Codes for Cardiovascular Screening Blood Tests

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

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Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate CPT code and the corresponding ICD-9-CM diagnosis code in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate CPT code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for the cardiovascular screening blood tests when submitted on the following Types of Bill (TOBs), listed in Table 3.

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

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

Facility Type	Type of Bill
SNF Outpatient	23X
CAH Outpatient***	85X
Federally Qualified Health Center (FQHC) (for dates of service on or after January 1, 2011)	77X See Additional Billing Instructions for FQHCs

***NOTE:** The benefit is covered when it is performed on an inpatient or outpatient basis in a hospital, CAH, or SNF (or FQHC for dates of service on or after January 1, 2011).

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for cardiovascular screening blood tests for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Cardiovascular screening blood tests provided by other facility types must be reimbursed by the SNF.

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

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

For dates of service on or after July 1, 2009, a CAH will be paid 101 percent of reasonable costs for outpatient clinical diagnostic laboratory tests, and the beneficiary is no longer required to be physically present in a CAH at the time the specimen is collected. However, the beneficiary must be an outpatient of the CAH and be receiving services directly from the CAH. In order for the beneficiary to be receiving services directly from the CAH, the beneficiary must either be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or an entity that is provider-based to the CAH.

Additional Billing Instructions for Rural Health Clinics (RHCs)

RHCs are not included in Table 3. RHCs may only bill for RHC services; laboratory services are not within the scope of the RHC benefit. However, if the RHC is provider-based and the base provider furnishes the laboratory test apart from the RHC, then the base provider may bill the laboratory test using the base provider's provider ID number. Payment will be made to the base provider, not to the RHC. If the facility is freestanding, then the individual practitioner bills the carrier/AB MAC for the laboratory test using the provider ID number.

Additional Billing Instructions for FQHCs

Dates of Service Prior to January 1, 2011

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

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

Dates of Service on or After January 1, 2011

The Affordable Care Act revised the list of preventive services paid by Medicare in the FQHC setting. For dates of service on or after January 1, 2011, the professional component of cardiovascular screening blood tests is a covered FQHC service when provided by an FQHC. FQHCs should follow these billing instructions to ensure that proper payment is made for services and to allow the Common Working File (CWF) to perform age and frequency editing.

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

- **Technical Component** for Provider-Based FQHCs:
  - The base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **Technical Component** for Independent FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component** for Provider-Based FQHCs and Freestanding FQHCs:
  - Detailed Healthcare Common Procedure Coding System (HCPCS) coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment. An additional line with revenue code 052X should be submitted with the appropriate CPT code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive encounter rate, and coinsurance or copayment and deductible will not apply.
  - If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/CPT code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.

Reimbursement Information

General Information

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

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses the cardiovascular screening blood tests under the Clinical Laboratory Fee Schedule.

Clinical Laboratory Fee Schedule Information

For more information about the Clinical Laboratory Fee Schedule, visit http://www.cms.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the cardiovascular screening blood tests depends on the type of facility providing the service. Table 4 lists the type of payment that facilities receive for cardiovascular screening blood tests.

Table 4 – Facility Payment Methodology for Cardiovascular Screening Blood Tests*

Facility Type	Basis of Payment
Hospital	Clinical Laboratory Fee Schedule
Skilled Nursing Facility (SNF)**	Clinical Laboratory Fee Schedule
Critical Access Hospital (CAH)	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of Medicare Physician Fee Schedule (MPFS) non-facility rate for professional component(s) of services
Federally Qualified Health Center (FQHC) for dates of service on or after January 1, 2011	All-Inclusive Encounter Rate

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

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for cardiovascular screening blood tests for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Cardiovascular screening blood tests provided by other facility types must be reimbursed by the SNF.

Reasons for Claim Denial

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

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

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Cardiovascular Screening Blood Tests

Resources

CMS Cardiovascular Disease Screening Web Page
http://www.cms.gov/CardiovasDiseaseScreening

Heart Disease and Stroke Prevention: Addressing the Nation's Leading Killers: At a Glance 2010
http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm

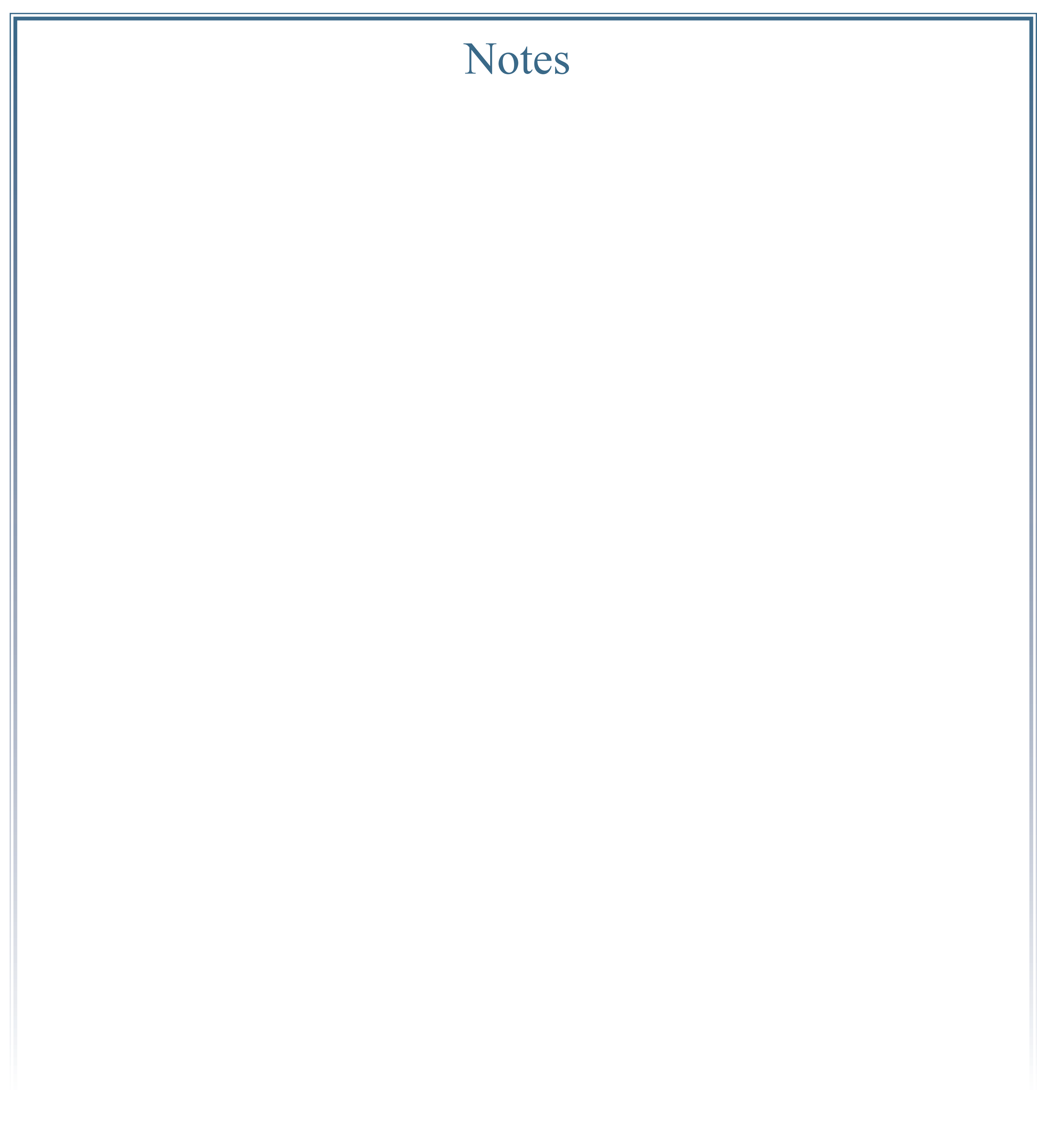
"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 100
http://www.cms.gov/manuals/downloads/clm104c18.pdf

Medicare Learning Network® (MLN) Preventive Services Educational Products Website
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

National Heart, Lung, and Blood Institute
http://www.nhlbi.nih.gov

More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes



Notes

Chapter 4
Annual Wellness Visit

Overview

For dates of service on or after January 1, 2011, Medicare will cover an Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS) at no cost to the beneficiary, so beneficiaries can work with their physicians to develop and update a personalized prevention plan. This new benefit will provide an ongoing focus on prevention that can be adapted as a beneficiary's health needs change over time.

NOTE: For more information on the Initial Preventive Physical Examination (IPPE), refer to Chapter 1 of this Guide.

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the beneficiary.

For dates of service on or after January 1, 2011, Medicare provides coverage of an AWV, including Personalized Prevention Plan Services (PPPS). The coinsurance or copayment and the deductible are waived.

Preparing Beneficiaries for the AWV

Providers can help eligible Medicare beneficiaries get ready for their AWV by encouraging them to 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; and
- A full list of current providers and suppliers involved in providing care.

AWV, Providing PPPS

The **first AWV providing PPPS** is a one-time Medicare benefit and includes the following key elements furnished to an eligible beneficiary by a health professional:

- Establishment of the beneficiary's medical/family history, including, at a minimum:
  - Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments;
  - Use or exposure to medications and supplements, including calcium and vitamins; and
  - Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the beneficiary at increased risk;
- Measurement of the beneficiary's height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the beneficiary's medical and family history;
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the beneficiary;
- Detection of any cognitive impairment that the beneficiary may have (includes the assessment of a beneficiary's cognitive function by direct observation, with due consideration of information obtained by way of patient reports or concerns raised by family members, friends, caretakers, or others);

- Review of a beneficiary's potential risk factors for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations;
- Review of the beneficiary's functional ability and level of safety, based on direct observation of the beneficiary, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations, including, at a minimum, assessment of the following:
    - Hearing impairment,
    - Ability to successfully perform activities of daily living,
    - Fall risk, and
    - Home safety;
- Establishment of a written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the USPSTF and Advisory Committee of Immunizations Practices (ACIP), the beneficiary's health status, screening history, and age-appropriate preventive services covered by Medicare;
- Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the beneficiary, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits; and
- Provision of personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

Subsequent AWV services providing PPPS include the following key elements furnished to an eligible beneficiary by a health professional:

- Update to the beneficiary's medical/family history;
- Measurements of a beneficiary's weight (or waist circumference), blood pressure, and other routine measurements as deemed appropriate, based on the beneficiary's medical and family history;
- Update to the list of the beneficiary's current medical providers and suppliers that are regularly involved in providing medical care to the beneficiary, as was developed at the first AWV providing PPPS;
- Detection of any cognitive impairment that the beneficiary may have;
- Update to the beneficiary's written screening schedule as developed at the first AWV providing PPPS;
- Update to the beneficiary's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the beneficiary, as was developed at the first AWV providing PPPS; and
- Furnish appropriate personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs.

Coverage Information

Effective for dates of service on or after January 1, 2011, Medicare provides coverage of an AWV for a beneficiary who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage and who has not received either an IPPE or an AWV within the past 12 months. Medicare pays for only one **first** AWV per beneficiary per lifetime. However, a beneficiary may receive subsequent AWVs if at least 12 months have passed since the last AWV. The AWV is a preventive wellness visit and is **not** a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. **Medicare Part B does not provide coverage for routine physical examinations.**

Stand Alone Benefit

The AWV providing PPPS benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

The AWV must be furnished by a health professional, meaning a physician (a doctor of medicine or osteopathy), a qualified non-physician practitioner (a physician assistant, nurse practitioner, or clinical nurse specialist), or by a medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician.

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

Documentation

Documentation must show that the health professionals provided, or provided and referred, all required components of the AWV. The physicians and/or qualified non-physician practitioners should use the appropriate screening tools normally used in a routine physician's practice.

If a significant, separately identifiable medically necessary Evaluation and Management (E/M) service is also performed, the physician and/or qualified non-physician practitioner must document this in the medical record. Refer to the "Documentation Guidelines for Evaluation and Management Services" for 1995 and 1997 at http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp on the Centers for Medicare & Medicaid Services (CMS) website, for recording the appropriate clinical information in the beneficiary's medical record. Include all referrals and a written medical plan in this documentation.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) codes, listed in Table 1, must be used to report the AWV.

Table 1 – HCPCS Codes for the AWV

HCPCS Code	Code Descriptor
G0438	Annual wellness visit, includes Personalized Prevention Plan of Service (PPPS), first visit
G0439	Annual wellness visit, includes PPPS, subsequent visit

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

Diagnosis Requirements

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

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS code in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

When health professionals provide a significant, separately identifiable medically necessary E/M service in addition to the AWV, they may use CPT codes 99201-99215 depending on the clinical appropriateness of the encounter. The E/M code should be reported with modifier -25, identifying the service as a significant, separately identifiable, E/M service from the reported AWV code.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code and revenue code in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

When health professionals provide a significant, separately identifiable, medically necessary E/M service in addition to the AWV, they may use CPT codes 99201-99215 depending on the clinical appropriateness of the encounter. The E/M CPT code should be reported with modifier -25, identifying the service as a significant, separately identifiable, E/M service from the reported AWV HCPCS code.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for the AWV benefit when submitted on the following TOBs and associated revenue codes listed in Table 2.

Table 2 – Facility Types and TOBs for the AWV

Facility Type	Type of Bill
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X
Hospital Outpatient	13X
Skilled Nursing Facility (SNF) Inpatient Part B	22X
SNF Outpatient	23X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	77X
CAH Outpatient*	85X

***NOTE:** Medicare pays all CAHs for the technical or facility component of the AWV.

Medicare pays only Method II CAHs for the professional component of the AWV (in addition to the facility payment) when those charges are reported under revenue codes 096X, 097X, or 098X.

Additional Billing Instructions for RHCs and FQHCs

If an AWV is provided in an RHC or FQHC, the professional portion of the service is billed to the FI/AB MAC using TOBs 71X and 77X, respectively, and must include HCPCS code G0438 or G0439.

FQHC TOB

Effective for dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

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Reimbursement Information

General Information

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

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses the AWV under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all AWV services.

Medicare Physician Fee Schedule (MPFS) Information

For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the AWV depends on the type of facility providing the service. Table 3 lists the type of payment that facilities receive for the AWV.

Table 3 – Facility Payment Methodology for the AWV*

Facility Type	Basis of Payment
Hospital Inpatient Part B including Critical Access Hospital (CAH)	Medicare Physician Fee Schedule (MPFS)
Hospital Outpatient	MPFS
Skilled Nursing Facility (SNF) Inpatient Part B**	MPFS
SNF Outpatient	MPFS
Rural Health Clinic (RHC)	All-Inclusive Encounter Rate
Federally Qualified Health Center (FQHC)	All-Inclusive Encounter Rate
CAH Outpatient	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

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

****NOTE:** The SNF consolidated billing provision allows separate Part B payment for an AWV for beneficiaries in a skilled Part A SNF stay; however, the SNF must submit these services on a 22X TOB. AWV services provided by other provider types must be reimbursed by the SNF.

Reasons for Claim Denial

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

- A second first AWV is billed for the same beneficiary.
- A subsequent AWV is billed less than 12 months after the previous covered AWV.

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Annual Wellness Visit

Resources

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

"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 280.5
http://www.cms.gov/manuals/downloads/bp102c15.pdf

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

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 140
http://www.cms.gov/manuals/downloads/clm104c18.pdf

Medicare Learning Network® (MLN) Preventive Services Educational Products Website
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

MLN "Medicare Preventive Services Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" (ICN 905706)
http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

MLN Matters® Article MM7079, "Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)"
http://www.cms.gov/MLNMattersArticles/downloads/MM7079.pdf

More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes

Notes

Chapter 5
Seasonal Influenza, Pneumococcal, and Hepatitis B Vaccinations

Overview

Influenza, pneumococcal infections, and hepatitis B are vaccine-preventable diseases that cause substantial illness and premature death in the United States each year. During an average year, there are on average more than 200,000 hospitalizations from influenza. An average of 36,000 Americans die each year from influenza and pneumonia, the 5th leading cause of death in the United States. The hepatitis B virus causes significant morbidity and mortality worldwide. According to the Centers for Disease Control and Prevention (CDC), an estimated 1.25 million Americans are infected with the hepatitis B virus (HBV), which attacks the liver and can cause liver cancer, liver failure, and death. The Medicare Program provides coverage for the seasonal influenza, pneumococcal, and hepatitis B vaccinations and their administration. These vaccines are safe, effective, and can help reduce disease incidence, morbidity, and mortality, ultimately reducing health care costs.

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

The coinsurance or copayment and deductible for the seasonal influenza virus vaccine, the pneumococcal vaccine, and the administration of those vaccines were already waived and are not affected by the Affordable Care Act.

For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible for the hepatitis B virus (HBV) vaccine and its administration are waived.

Advisory Committee on Immunization Practices (ACIP)

The CDC Advisory Committee on Immunization Practices (ACIP) develops written recommendations for the routine administration of vaccines to the pediatric and adult populations, along with schedules regarding the appropriate periodicity, dosage, and contraindications applicable to the vaccines. ACIP is the only entity in the Federal Government that makes such recommendations.

Clinicians should refer to published guidelines for current recommendations related to immunization. Refer to the latest ACIP recommendations regarding immunizations and vaccines at http://www.cdc.gov/vaccines/recs/acip on the Internet.

Seasonal Influenza (Flu) Virus Vaccine

Influenza, also known as the flu, is a contagious disease caused by influenza viruses that generally occurs during the winter months. It attacks the respiratory tract in humans (nose, throat, and lungs). Influenza is a serious illness that can lead to pneumonia. The risks for complications, hospitalizations, and deaths from influenza are higher among individuals aged 65 and older, young children, and

H1N1 Influenza

The information in this chapter relates to seasonal influenza only. For more information related to Medicare coverage and policy related to H1N1 influenza, visit http://www.cms.gov/H1N1 on the Centers for Medicare & Medicaid Services (CMS) website.

persons of any age with certain underlying health conditions than the risks for complications among healthy older children and younger adults. A seasonal influenza vaccination is still the best way to prevent influenza and its severe complications.

Risk Factors for Influenza

Medicare provides coverage of the seasonal influenza virus vaccine and its administration for all Medicare beneficiaries regardless of risk for the disease; however, some individuals are at greater risk for contracting influenza. Vaccination is recommended for all individuals aged six months and older.

While everyone should get a seasonal influenza vaccine each influenza season, it's especially important that certain groups get vaccinated either because they are at high risk of having serious influenza-related complications or because they live with or care for people at high risk for developing influenza-related complications. For more information, refer to the most recent recommendations at http://www.cdc.gov/flu/protect/keyfacts.htm on the CDC website.

NOTE: For general information about planning a seasonal influenza vaccination clinic, see the Planning a Flu Vaccination Clinic section at the end of this chapter.

Who Should Not Get the Seasonal Influenza Virus Vaccine

According to the CDC, individuals in the following groups should not receive the seasonal influenza virus vaccine without consulting a physician:

- Individuals with a severe allergy to chicken eggs,
- Individuals who have had a severe reaction to a seasonal influenza virus vaccination in the past,
- Individuals who previously had onset of Guillain-Barré syndrome during the six weeks after receiving the seasonal influenza virus vaccine,
- Children aged younger than six months, and
- Individuals who have a moderate to severe illness with a fever (these individuals should wait until their symptoms improve).

Did You Know?

Unvaccinated health care professionals and their staff can spread the highly contagious influenza virus to patients and are a key cause of influenza outbreaks among patients and long-term care residents.

Don't forget to immunize yourself and your staff.

Protect your patients. Protect your family. Protect yourself. Get your flu shot. Not the Flu.

For more information on ACIP's immunization recommendations for health care professionals, visit http://www.cdc.gov/vaccines/pubs/ACIP-list.htm on the CDC website.

Coverage Information

Medicare provides coverage of one seasonal influenza virus vaccine per influenza season for all beneficiaries. This may mean that a beneficiary will receive more than one seasonal influenza vaccination in a 12-month period. Medicare may provide coverage for more than one seasonal influenza vaccination per influenza season if a physician determines, and documents in the beneficiary's medical record, that the additional vaccination is reasonable and medically necessary.

Medicare does not require that the seasonal influenza virus vaccine be administered under a physician's order or supervision. Therefore, the beneficiary may receive the vaccine upon request without a physician's order. A physician is not required to be present during the vaccination for the beneficiary to receive coverage under Medicare; however, the law in individual states may require a physician's presence, a physician's order, or other physician involvement.

Medicare provides coverage for the seasonal influenza virus vaccine and its administration as a Medicare Part B benefit. If the beneficiary receives the immunization from a Medicare-enrolled provider, the beneficiary will pay nothing (there is no coinsurance or copayment and no Medicare Part B deductible) for the vaccine, although the beneficiary may incur a coinsurance or copayment for the administration of the vaccine if the provider does not accept assignment.

Reminder

Seasonal influenza virus vaccine plus its administration are covered Part B benefits. Note that the seasonal influenza virus vaccine is **not** a Part D covered drug.

How Often Will Medicare Pay for Seasonal Influenza Vaccination?

Medicare will pay for the seasonal influenza virus vaccine once per influenza season. In some cases, this may mean twice in one year. For example, if a beneficiary received a vaccination in January 2010 for one influenza season, the beneficiary could be inoculated again in October 2010 for another influenza season.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, listed in Table 1, must be used to report seasonal influenza vaccination. Providers may list charges for other services on the same bill as the seasonal influenza virus vaccine; however, the applicable codes for the additional services must be used.

Stand Alone Benefit

The seasonal influenza virus vaccine covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

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

HCPCS/CPT Code	Code Descriptor
90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90658*	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use

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HCPCS/CPT Code	Code Descriptor
90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
Q2035**	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
Q2036**	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
Q2037**	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
Q2038**	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
Q2039**	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)
G0008	Administration of influenza virus vaccine

***NOTE:** Medicare will not recognize CPT code 90658 for dates of service on or after January 1, 2011.

****NOTE:** For dates of service on or after October 1, 2010, HCPCS codes Q2035, Q2036, Q2037, Q2038, and Q2039 will replace CPT code 90658 for Medicare payment purposes during the 2010-2011 influenza season.

Diagnosis Requirements

Medicare providers must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes, listed in Table 2.

If the **sole** purpose for the visit was to receive the seasonal influenza virus vaccine or if the seasonal influenza virus vaccine is the only service billed on a claim, the provider must report diagnosis code V04.81. However, if the purpose of the visit was to receive both the seasonal influenza virus vaccine **and** the pneumococcal vaccine, Medicare providers must report diagnosis code V06.6.

Table 2 – Diagnosis Codes for Influenza

ICD-9-CM Diagnosis Code	Code Descriptor
V04.81	Need for prophylactic vaccination and inoculation against viral diseases; influenza
V06.6	Need for prophylactic vaccination and inoculation against combinations of diseases; Streptococcus pneumoniae (pneumococcus) and influenza

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Billing Requirements

General Requirements

- All billers using the X12 837 Institutional electronic claim format (or Form CMS-1450) and the X12 837 Professional electronic claim format (or Form CMS-1500) should note that all data fields required for any institutional or professional claim are also required for the vaccines and their administration. Medicare providers should bill in accordance with the instructions within provider manuals provided by the carrier/AB Medicare Administrative Contractor (carrier/AB MAC). Additionally, coding specific to these benefits is required.
- Medicare providers and suppliers are responsible for completing required items on the claim forms with correct information obtained from the beneficiary. If roster billing for the seasonal influenza virus vaccine, the Medicare provider should ensure that key data elements, such as "Date of Birth," provide sufficient beneficiary information for the contractor to resolve incorrect Health Insurance Claim Numbers (HICNs). However, if the contractor cannot determine the correct HICN through other information on the claim or through beneficiary contact, the claim will be rejected. (Refer to the Mass Immunizers/Roster Billers section later in this chapter for more information on roster billing.)
- If a physician provides other Medicare-covered services during the visit in which the immunization is given, the physician may code and bill those other medically necessary services, including Evaluation and Management (E/M) services. Refer to the "Documentation Guidelines for Evaluation and Management Services" for 1995 and 1997 at http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS website.
- Since the coinsurance or copayment and Medicare Part B deductible are waived, a Medicare beneficiary has a right to receive this benefit without incurring any out-of-pocket expense.
- In addition, the entity that furnishes the seasonal influenza virus vaccine and the entity that administers the seasonal influenza virus vaccine are each required by law to submit a claim to Medicare on behalf

Additional Billing Guidelines for Non-Traditional Providers Billing Seasonal Influenza Virus Immunizations

Non-traditional providers and suppliers such as drug stores, senior centers, shopping malls, and self-employed nurses may bill a carrier/AB Medicare Administrative Contractor (carrier/AB MAC) for seasonal influenza virus vaccinations if the provider meets state licensure requirements to furnish and administer seasonal influenza virus vaccinations. Providers and suppliers should contact their local carrier/AB MAC provider enrollment department to enroll in the Medicare Program.

A registered nurse/pharmacist employed by a physician may use the physician's provider number if the nurse/pharmacist, in a location other than the physician's office, provides seasonal influenza virus vaccinations. If the nurse/pharmacist is not working for the physician when the services are provided (e.g., a nurse/pharmacist is "moonlighting," administering seasonal influenza virus vaccinations at a shopping mall at his or her own direction and not that of the physician), the nurse/pharmacist may obtain a provider number and bill the carrier/AB MAC directly. However, if the nurse/pharmacist is working for the physician when the services are provided, the nurse/pharmacist would use the physician's provider number.

The following providers of services may bill Fiscal Intermediaries/AB MACs (FIs/AB MACs) for seasonal influenza virus vaccines:

- Hospitals,
- Skilled Nursing Facilities (SNFs),
- Critical Access Hospitals (CAHs),
- Home Health Agencies (HHAs),
- Comprehensive Outpatient Rehabilitation Facilities (CORFs),
- Independent Renal Dialysis Facilities (RDFs),
- Hospital-based RDFs, and
- Indian Health Service (IHS)/Tribally owned and/or operated hospitals and hospital-based facilities.

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 seasonal influenza vaccination and pays $2.50 of the cost from its budget may bill the carrier/AB MAC the $5.00 cost that is not paid out of its budget.

- When an entity receives donated seasonal influenza virus vaccine or receives donated services for the administration of the seasonal influenza virus vaccine, the provider may bill Medicare for the portion of the vaccination that was not donated. **Mass immunizers must provide the Medicare beneficiary with a record of the seasonal influenza vaccination.**

Billing and Coding Requirements When Submitting Claims to Carriers/AB MACs

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS code for the administration of the seasonal influenza virus vaccine (G0008), the appropriate HCPCS/CPT code for the seasonal influenza virus vaccine, and the corresponding ICD-9-CM diagnosis code (V04.81 or V06.6) in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code for the administration of the seasonal influenza virus vaccine (G0008), the appropriate HCPCS/CPT code for the seasonal influenza virus vaccine, the appropriate revenue code (0636 or 0771), and the corresponding ICD-9-CM diagnosis code (V06.6 or V04.81) in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for seasonal influenza virus vaccination services when submitted on the following TOBs and associated revenue codes, listed in Table 3.

Table 3 – Facility Types, TOBs, and Revenue Codes for Seasonal Influenza Virus Vaccination*

Facility Type	Type of Bill	Revenue Code
Hospital, other than Indian Health Service (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	0636 – vaccine 0771 – administration
IHS Hospital	12X, 13X	0636 – vaccine 0771 – administration
IHS CAH	85X	0636 – vaccine 0771 – administration
Skilled Nursing Facility (SNF) Inpatient Part B**	22X	0636 – vaccine 0771 – administration
SNF Outpatient	23X	0636 – vaccine 0771 – administration
Home Health Agency (HHA)***	34X	0636 – vaccine 0771 – administration
Independent and Hospital-Based Renal Dialysis Facility (RDF)	72X	0636 – vaccine 0771 – administration
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0636 – vaccine 0771 – administration
CAH Method I and II****	85X	0636 – vaccine 0771 – administration

***NOTE:** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are not included in this table since they do not report charges for seasonal influenza virus vaccination on their claims. Costs for the seasonal influenza virus vaccination are included in the cost report, no line items are billed, and payment for the vaccine is made via the cost report at cost settlement. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website.

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for seasonal influenza virus vaccination and its administration for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Seasonal influenza virus vaccination and its administration provided by other facility types must be reimbursed by the SNF.

*****NOTE:** Medicare will not pay for a skilled nursing visit by an HHA nurse under the home health benefit when the sole purpose for an HHA visit is to administer a vaccine (seasonal influenza virus, pneumococcal, or hepatitis B). However, the vaccine and its administration are covered under the home health benefit. The administration should include charges only for the supplies being used and the cost of the injection. HHAs are not permitted to charge for travel time or other expenses (e.g., gasoline).

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

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

Additional Billing Instructions

- **Other Charges** – Other charges may be listed on the same bill; however, the Medicare provider must include the applicable codes for the additional charges.
- **Certified Part A Providers** – With the exception of hospice providers, certified Part A providers must bill the FI/AB MAC for this Part B benefit.
- **Hospice Providers** – Hospice providers bill the carrier/AB MAC using the X12 837 Professional electronic claim format (or Form CMS-1500).
- **Non-Medicare Participating Providers** – Non-Medicare participating provider facilities bill the local carrier/AB MAC.
- **HHAs** – HHAs that have a Medicare-certified component and a non-Medicare certified component may elect to furnish the seasonal influenza virus vaccination through the non-certified component and bill the carrier/AB MAC.
- **Hospitals** – Hospitals bill the FI/AB MAC for inpatient vaccination.
- **RHCs and FQHCs** – Independent and provider-based RHCs and FQHCs do not report charges for the seasonal influenza virus vaccine and its administration on their claims. Costs for the seasonal influenza virus vaccination and its administration are included in the cost report, no line items are billed, and payment for the vaccine is made via the cost report at cost settlement. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website. If there is a qualifying visit in addition to the vaccine administration, the RHC/FQHC bills for the visit without adding the cost of the seasonal influenza virus vaccine and its administration to the charge for the visit on the claim.
- **Dialysis Patients** – On claims for a dialysis patient of a hospital or hospital-based renal dialysis facility, the hospital bills the FI/AB MAC.

Reimbursement Information

General Information

Medicare provides coverage for the seasonal influenza virus vaccine and its administration as a Medicare Part B benefit. If the beneficiary receives the immunization from a Medicare-enrolled provider, the beneficiary will pay nothing (there is no coinsurance or copayment and no Medicare Part B deductible) for the vaccine, although the beneficiary may incur a coinsurance or copayment for the administration of the vaccine if the provider does not accept assignment.

All Medicare providers of the seasonal influenza virus vaccine must accept assignment for the **vaccine**. It is not mandatory for providers of the seasonal influenza virus vaccine to accept assignment for the **administration** of the vaccine. However, a Medicare provider must accept assignment of **both** the vaccine and the administration of the vaccine if a provider is enrolled as a provider type "Mass Immunization Roster Biller," submits roster bills, or participates in the centralized billing program. (See the Mass Immunizers/Roster Billers and Centralized Billing sections of this chapter for more information.)

- A physician, provider, or supplier may not collect payment for an immunization from a beneficiary and instruct the beneficiary to submit the claim to Medicare for payment. Medicare law requires that the physicians, providers, and suppliers submit a claim for services to Medicare on the beneficiary's behalf.
- Medicare will pay two administration fees if a beneficiary receives both the seasonal influenza virus and the pneumococcal vaccines on the same day.
- HCPCS code G0008 (administration of seasonal influenza virus vaccine) may be paid in addition to other services, including E/M services, and is **not** subject to rebundling charges.
- When a physician sees a beneficiary for the **sole** purpose of administering the seasonal influenza virus vaccine, the physician may **not** routinely bill for an office visit. However, if the physician provides services constituting an "office visit" level of service, the physician may bill for an office visit in addition to the seasonal influenza virus vaccine and administration. Medicare will pay for the office visit in addition to the vaccine and administration if it is reasonable and medically necessary.
- Medicare providers enrolled as a "Mass Immunization Roster Biller" must roster bill and accept assignment on both the administration and the vaccine. (Refer to the Mass Immunizers/Roster Billers section of this chapter for more information on this type of billing.)

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare links payment of the administration of the seasonal influenza virus vaccine to payment for services under the Medicare Physician Fee Schedule (MPFS), but does not actually reimburse under the MPFS. The payment for the administration is the lesser of the actual charge or the MPFS amount for a comparable injection.

Medicare Physician Fee Schedule (MPFS) Information

For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Participating Providers

- Participating institutional providers and physicians, providers, and suppliers who 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 seasonal influenza virus vaccine. They may not collect payment from beneficiaries.

Non-Participating Providers

- Physicians, providers, and suppliers who do not accept assignment may never advertise the service as free since the beneficiary may incur an out-of-pocket expense after Medicare has paid 100 percent of the Medicare-allowed amount.
- Non-participating physicians, providers, and suppliers who do not accept assignment on the **administration** of the vaccine may collect payment from the beneficiary, but they **must submit an unassigned claim on the beneficiary's behalf**. All physicians, providers, and suppliers must accept assignment for the Medicare vaccine payment rate and may not collect payment from the beneficiary for the **vaccine**.
- The limiting charge provision does not apply to the seasonal influenza virus vaccine benefit. Non-participating physicians and suppliers who do not accept assignment for the administration of the seasonal influenza virus vaccine may collect their usual charges (i.e., the amount charged to a patient who is not a Medicare beneficiary) for the **administration** of the vaccine. When non-participating physicians or suppliers provide the services, the beneficiary is responsible for

paying the difference between what the physician or supplier charges and the amount Medicare allows for the **administration** fee. **However, all physicians and suppliers, regardless of participation status, must accept assignment of the Medicare vaccine payment rate and may not collect payment from the beneficiary for the vaccine.**

- The five percent payment reduction for physicians who do not accept assignment does not apply to the administration of the seasonal influenza virus vaccine. Only items and services covered under the limiting charge are subject to the five percent payment reduction.

No Legal Obligation to Pay

- Non-Governmental Entities – Non-governmental entities (providers, physicians, suppliers) that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. For example, Medicare may not pay for seasonal influenza virus vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or if an employer offers free vaccinations to its employees.
  - Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients.
  - When an employer offers free vaccinations to its employees, the employer must offer the free vaccination to an employee who is also a Medicare beneficiary. The employer does not have to offer free vaccinations to its non-Medicare employees.
  - However, non-governmental entities that do not charge patients who are unable to pay or reduce their charge for patients of limited means (sliding fee scale), but do expect to be paid if a patient has health insurance that covers the services provided, may bill Medicare and expect payment.
- State and Local Governmental Entities – Governmental entities, such as public health clinics, may bill Medicare for the seasonal influenza virus vaccine administered to Medicare beneficiaries when services are provided free of charge to non-Medicare patients.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the seasonal influenza virus **vaccine** depends on the type of facility providing the service. Table 4 lists the type of payment that facilities receive for the seasonal influenza virus vaccine.

Table 4 – Facility Types, TOBs, and Payment Methodology for Seasonal Influenza Virus Vaccine*

Facility Type	Type of Bill	Basis of Payment
Hospital, other than Indian Health Service (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Reasonable cost
IHS Hospital	12X, 13X	95% of Average Wholesale Price (AWP)
IHS CAH	85X	95% of AWP

Facility Type	Type of Bill	Basis of Payment
Skilled Nursing Facility (SNF)	22X, 23X	Reasonable cost
Home Health Agency (HHA)	34X	Reasonable cost
Independent Renal Dialysis Facility (RDF)	72X	95% of AWP
Hospital-Based RDF	72X	Reasonable cost
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	95% of AWP
CAH Method I and Method II	85X	Reasonable cost

***NOTE:** RHCs and FQHCs are not included in this table since they do not report charges for seasonal influenza virus vaccination on their claims. Costs for the seasonal influenza virus vaccination are included in the cost report, no line items are billed, and payment for the vaccine is made via the cost report at cost settlement. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website.

However, for dates of service on or after January 1, 2011, the professional component of the vaccine and its administration is a covered FQHC service when provided by an FQHC. FQHCs should report pneumococcal, seasonal influenza, and hepatitis B vaccine and their administration separately on a 77X TOB with the appropriate HCPCS/CPT codes and revenue code 052X. The service is paid in the manner as all other Medicare FQHC services. This information is being captured for data collection and gathering purposes only.

Medicare reimbursement for the **administration** of the seasonal influenza virus vaccine depends on the type of facility providing the service. Table 5 lists the type of payment that facilities receive for the administration of the seasonal influenza virus vaccine.

Table 5 – Facility Types, TOBs, and Payment Methodology for Administration of Seasonal Influenza Virus Vaccine*

Facility Type	Type of Bill	Basis of Payment
Hospital, other than Indian Health Service (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS 94% of submitted charges for Maryland hospitals under the jurisdiction of the Health Services Cost Review Commission (HSCRC)

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Facility Type	Type of Bill	Basis of Payment
IHS Hospital	12X, 13X	Medicare Physician Fee Schedule (MPFS) amount associated with CPT code 90471
IHS CAH	85X	MPFS amount associated with CPT code 90471
Skilled Nursing Facility (SNF)	22X, 23X	MPFS amount associated with CPT code 90471
Home Health Agency (HHA)	34X	OPPS
Independent Renal Dialysis Facility (RDF)	72X	MPFS amount associated with CPT code 90471
Hospital-Based RDF	72X	Reasonable cost
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	MPFS amount associated with CPT code 90471
CAH Method I and Method II	85X	Reasonable cost

***NOTE:** RHCs and FQHCs are not included in this table since they do not report charges for seasonal influenza virus vaccination on their claims. Costs for the seasonal influenza virus vaccination are included in the cost report, no line items are billed, and payment for the vaccine is made via the cost report at cost settlement. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website.

Reasons for Claim Denial

The following is an example of a situation when Medicare may deny coverage of seasonal influenza virus vaccination:

- A beneficiary requests more than one seasonal influenza virus vaccination during the same influenza season, and the Medicare provider cannot justify the medical necessity of the second vaccination.

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

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Pneumococcal Vaccine

Pneumococcal disease is an infection caused by the bacteria Streptococcus pneumoniae, also known as pneumococcus. The most common types of infections caused by this bacterium include: middle ear infections, pneumonia, blood stream infections (bacteremia), sinus infections, and meningitis. Invasive pneumococcal infection kills thousands of people in the United States each year, most of them aged 65 and older. While influenza viruses generally strike during the winter months, pneumococcal disease occurs year-round. The pneumococcal vaccine is very good at protecting adults against invasive pneumococcal disease and preventing severe illness, hospitalization, and death. Medicare provides coverage of the pneumococcal vaccine and its administration for all Medicare beneficiaries regardless of risk for the disease.

Medicare coverage of pneumococcal polysaccharide vaccine (PPV) and its administration began for dates of service on or after July 1, 1981. Coverage of pneumococcal conjugate vaccine and its administration began for dates of service on or after January 1, 2008.

Risk Factors for Pneumococcal Disease

The Centers for Disease Control and Prevention (CDC) identifies high priority target groups for the pneumococcal vaccination. For more information, refer to the most recent recommendations at http://www.cdc.gov/vaccines/vpd-vac/pneumo/in-short-both.htm#who on the CDC website.

NOTE: All individuals aged 65 and older should get both the seasonal influenza and pneumococcal vaccinations.

Coverage Information

Medicare generally provides coverage of pneumococcal vaccination once in a lifetime for all Medicare beneficiaries. (The beneficiary should not have received the pneumococcal vaccine within the last five years.) Medicare may provide coverage of additional vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status. (Refer to the Revaccination section below.)

- Those administering the vaccine should not require the beneficiary to show his or her immunization record prior to receiving the pneumococcal vaccine, nor is it necessary to review the beneficiary's complete medical record if it is not available.
- If the beneficiary is competent, it is acceptable to rely on the beneficiary's verbal history to determine the beneficiary's prior vaccination status.
- If the beneficiary is uncertain about his or her vaccination history for the last five years, the vaccine should be administered.
- If the beneficiary is certain of being vaccinated within the last five years, the vaccine should not be administered.
- If the beneficiary is certain of being vaccinated and that more than five years have passed since receipt of the previous dose, revaccination is not appropriate unless the beneficiary is considered to be at highest risk.

Reminder

Pneumococcal vaccine plus its administration are covered Part B benefits. Note that pneumococcal vaccine is **not** a Part D covered drug.

Stand Alone Benefit

The pneumococcal vaccine covered by Medicare is a stand alone billable service separate from the Initial Preventive Physical Examination (IPPE) and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

Medicare does not require the vaccine to be administered under a physician's order or supervision. Therefore, the beneficiary may receive the vaccine upon request without a physician's order. A physician is not required to be present during the vaccination for the beneficiary to receive coverage under Medicare; however, the law in individual states may require a physician's presence, a physician's order, or other physician involvement.

Medicare provides coverage for the pneumococcal immunization as a Medicare Part B benefit. If the beneficiary receives the immunization from a Medicare-enrolled provider, the beneficiary will pay nothing (there is no coinsurance or copayment and no Medicare Part B deductible) for the vaccine, although the beneficiary may incur a coinsurance or copayment for the administration of the vaccine if the provider does not accept assignment.

NOTE: Medicare provides coverage of pediatric pneumococcal vaccine.

Revaccination

Pneumococcal vaccine is typically administered to adults once in a lifetime. However, revaccination may be appropriate for beneficiaries at highest risk for pneumococcal disease and those most likely to have rapid declines in antibody levels. This group includes individuals with the following conditions:

- Functional or anatomic asplenia (e.g., from sickle cell disease or splenectomy);
- Human Immunodeficiency Virus (HIV);
- Leukemia;
- Lymphoma;
- Hodgkin's disease;
- Multiple myeloma;
- Generalized malignancy;
- Chronic renal failure;
- Nephrotic syndrome; and
- Other conditions associated with immunosuppression, such as organ or bone marrow transplantation, and individuals receiving immunosuppressive chemotherapy, including long-term corticosteroids.

NOTE: If a beneficiary who is not at highest risk is revaccinated because of uncertainty about his or her pneumococcal vaccination status, Medicare will pay for the pneumococcal revaccination. Routine revaccinations of beneficiaries aged 65 and older who are not at highest risk are not appropriate.

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, listed in Table 6, must be used to report pneumococcal vaccination services. Providers may list charges for other services on the same bill as the pneumococcal vaccine; however, the applicable codes for the additional services must be used.

Table 6 – HCPCS/CPT Codes for Pneumococcal Vaccines and Administration

HCPCS/CPT Code	Code Descriptor
90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
G0009	Administration of pneumococcal vaccine

Diagnosis Requirements

Medicare providers must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes, listed in Table 7.

If the **sole** purpose of the visit was to receive the pneumococcal vaccine or if the pneumococcal vaccine is the only service billed on a claim, the provider must report diagnosis code V03.82. However, if the purpose of the visit was to receive both the pneumococcal **and** the seasonal influenza virus vaccine, providers must report diagnosis code V06.6.

Table 7 – Diagnosis Codes for Pneumococcus

ICD-9-CM Diagnosis Code	Code Descriptor
V03.82	Need for prophylactic vaccination and inoculation against bacterial diseases; other specified vaccinations against single bacterial diseases; Streptococcus pneumoniae (pneumococcus)
V06.6	Need for prophylactic vaccination and inoculation against combinations of diseases; Streptococcus pneumoniae (pneumococcus) and influenza

Billing Requirements

General Requirements

- All billers using the X12 837 Institutional electronic claim format (or Form CMS-1450) and the X12 837 Professional electronic claim format (or Form CMS-1500) should note that all data fields required for any institutional or professional claim are also required for vaccines and their administration. Medicare providers should bill in accordance with the instructions within provider manuals provided by the carrier/AB Medicare Administrative Contractor (carrier/AB MAC). Additionally, coding specific to these benefits is required.

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- Medicare providers and suppliers are responsible for completing required items on the claims forms with correct information obtained from the beneficiary. If roster billing for the pneumococcal vaccine, the Medicare provider should ensure that key data elements, such as "Date of Birth," provide sufficient beneficiary information for the contractor to resolve incorrect Health Insurance Claim Numbers (HICNs). However, if the contractor cannot determine the correct HICN through other information on the claim or through beneficiary contact, the claim will be rejected. (Refer to the Mass Immunizers/Roster Billers section later in this chapter for more information on roster billing.)
- Medicare does not pay solely for counseling and education for pneumococcal vaccinations. If a physician provides other Medicare-covered services during the visit in which the immunization is given, the physician may code and bill those other medically necessary services, including Evaluation and Management (E/M) services. Refer to the "Documentation Guidelines for Evaluation and Management Services" for 1995 and 1997 at http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp on the Centers for Medicare & Medicaid Services (CMS) website.
- Since the coinsurance or copayment and Medicare Part B deductible are waived, a Medicare beneficiary has a right to receive this benefit without incurring any out-of-pocket expense.

Additional Billing Guidelines for Non-Traditional Providers Billing Pneumococcal Immunizations

Non-traditional providers and suppliers such as drug stores, senior centers, shopping malls, and self-employed nurses may bill a carrier/AB MAC for pneumococcal vaccines if the provider meets state licensure requirements to furnish and administer pneumococcal vaccinations. Providers and suppliers should contact their local carrier/AB MAC provider enrollment department to enroll in the Medicare Program.

A registered nurse/pharmacist employed by a physician may use the physician's provider number if the nurse/pharmacist, in a location other than the physician's office, provides pneumococcal vaccinations. If the nurse/pharmacist is not working for the physician when the services are provided (e.g., a nurse/pharmacist is "moonlighting," administering pneumococcal vaccinations at a shopping mall at his or her own direction and not that of the physician), the nurse/pharmacist may obtain a provider number and bill the carrier/AB MAC directly. However, if the nurse/pharmacist is working for the physician when the services are provided, the nurse/pharmacist would use the physician's provider number.

The following providers of services may bill Fiscal Intermediaries/AB MACs (FIs/AB MACs) for pneumococcal vaccinations:

- Hospitals,
- Skilled Nursing Facilities (SNFs),
- Critical Access Hospitals (CAHs),
- Home Health Agencies (HHAs),
- Comprehensive Outpatient Rehabilitation Facilities (CORFs),
- Independent Renal Dialysis Facilities (RDFs),
- Hospital-based RDFs, and
- Indian Health Service (IHS)/Tribally owned and/or operated hospitals and hospital-based facilities.

- In addition, the entity that furnishes the vaccine and the entity that administers the vaccine are each required by law to submit a claim to Medicare on behalf of the beneficiary. The entity may bill Medicare for the amount not subsidized from its budget. For example, an entity that incurs a cost of $7.50 per pneumococcal vaccination and pays $2.50 of the cost from its budget may bill the carrier/AB MAC the $5.00 cost that is not paid out of its budget.
- When an entity receives donated pneumococcal vaccine or receives donated services for the administration of the vaccine, the provider may bill Medicare for the portion of the vaccination that was not donated. **Mass immunizers must provide the Medicare beneficiary with a record of the pneumococcal vaccination.**

Billing and Coding Requirements When Submitting Claims to Carriers/AB MACs

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS code for the administration of the pneumococcal vaccine (G0009), the appropriate CPT code for the vaccine (90669, 90670, or 90732), and the corresponding ICD-9-CM diagnosis code (V03.82 or V06.6) in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code for the administration of the pneumococcal vaccine (G0009), the appropriate CPT code for the vaccine (90669, 90670, or 90732), the appropriate revenue code (0636 or 0771), and the corresponding ICD-9-CM diagnosis code (V03.82 or V06.6) in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

FIs/AB MACs will reimburse for pneumococcal vaccination services when submitted on the following TOBs and associated revenue codes, listed in Table 8.

Table 8 – Facility Types, TOBs, and Revenue Codes for Pneumococcal Vaccination*

Facility Type	Type of Bill	Revenue Code
Hospital, other than Indian Health Service (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	0636 – vaccine 0771 – administration
IHS Hospital	12X, 13X	0636 – vaccine 0771 – administration
IHS CAH	85X	0636 – vaccine 0771 – administration

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Facility Type	Type of Bill	Revenue Code
Skilled Nursing Facility (SNF) Inpatient Part B**	22X	0636 – vaccine 0771 – administration
SNF Outpatient	23X	0636 – vaccine 0771 – administration
Home Health Agency (HHA)***	34X	0636 – vaccine 0771 – administration
Independent and Hospital-Based Renal Dialysis Facility (RDF)	72X	0636 – vaccine 0771 – administration
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0636 – vaccine 0771 – administration
CAH Method I and II****	85X	0636 – vaccine 0771 – administration

***NOTE:** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are not included in this table since they do not report charges for a pneumococcal vaccination on their claims. Costs for the pneumococcal vaccination are included in the cost report, no line items are billed, and payment for the vaccine is made via the cost report at cost settlement. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website.

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for pneumococcal vaccination and its administration for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Pneumococcal vaccination and its administration provided by other facility types must be reimbursed by the SNF.

*****NOTE:** Medicare will not pay for a skilled nursing visit by an HHA nurse under the home health benefit when the sole purpose for an HHA visit is to administer a vaccine (seasonal influenza, pneumococcal, or hepatitis B). However, the vaccine and its administration are covered under the home health benefit. The administration should include charges only for the supplies being used and the cost of the injection. HHAs are not permitted to charge for travel time or other expenses (e.g., gasoline).

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

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

Additional Billing Instructions

- **Other Charges** – Other charges may be listed on the same bill; however, the Medicare provider must include the applicable codes for the additional charges.
- **Certified Part A Providers** – With the exception of hospice providers, certified Part A providers must bill the FI/AB MAC for this Part B benefit.
- **Hospice Providers** – Hospice providers bill the carrier/AB MAC using the X12 837 Professional electronic claim format (or Form CMS-1500).

- **Non-Medicare Participating Providers** – Non-Medicare participating provider facilities bill the local carrier/AB MAC.
- **HHAs** – HHAs that have a Medicare-certified component and a non-Medicare certified component may elect to furnish the pneumococcal vaccination through the non-certified component and bill the carrier/AB MAC.
- **Hospitals** – Hospitals bill the FI/AB MAC for inpatient vaccination.
- **RHCs and FQHCs** – Independent and provider-based RHCs and FQHCs do not report charges for a pneumococcal vaccine and its administration on their claims. Costs for the pneumococcal vaccine and its administration are included in the cost report, no line items are billed, and payment for the vaccine is made via the cost report at cost settlement. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website. If there is a qualifying visit in addition to the vaccine administration, the RHC/FQHC bills for the visit without adding the cost of the pneumococcal vaccine and its administration to the charge for the visit on the claim.
- **Dialysis Patients** – On claims for a dialysis patient of a hospital or hospital-based renal dialysis facility, the hospital bills the FI/AB MAC.

Reimbursement Information

General Information

Medicare provides coverage for the pneumococcal vaccine and its administration as a Medicare Part B benefit. If the beneficiary receives the immunization from a Medicare-enrolled provider, the beneficiary will pay nothing (there is no coinsurance or copayment and no Medicare Part B deductible) for the vaccine, although the beneficiary may incur a coinsurance or copayment for the administration of the vaccine if the provider does not accept assignment.

National Correct Coding Initiative (NCCI) Edits

Refer to the currently applicable bundled carrier processed procedures at http://www.cms.gov/NationalCorrectCodInitEd on the CMS website.

All Medicare providers of the pneumococcal vaccine must accept assignment for the **vaccine**. It is not mandatory for providers of the pneumococcal vaccine to accept assignment for the **administration** of the vaccine. However, a Medicare provider must accept assignment of **both** the vaccine and the administration of the vaccine if a provider is enrolled as a provider type "Mass Immunization Roster Biller," submits roster bills, or participates in the centralized billing program. (Refer to the Mass Immunizers/Roster Billers and Centralized Billing sections of this chapter for more information.)

- A physician, provider, or supplier may not collect payment for an immunization from a beneficiary and instruct the beneficiary to submit the claim to Medicare for payment. Medicare law requires that 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 seasonal influenza and the pneumococcal vaccines on the same day.
- HCPCS code G0009 (administration of pneumococcal vaccine) may be paid in addition to other services, including E/M services, and is **not** subject to rebundling charges.
- When a physician sees a beneficiary for the **sole** purpose of administering the pneumococcal vaccine, the physician may **not** routinely bill for an office visit. However, if the physician provides services

constituting an "office visit" level of service, the physician may bill for an office visit in addition to the pneumococcal vaccine and administration. Medicare will pay for the office visit in addition to the vaccine and administration if it is reasonable and medically necessary.

- Medicare providers enrolled as a "Mass Immunization Roster Biller" must roster bill and accept assignment on both the administration and the vaccine. (Refer to the Mass Immunizers/Roster Billers section in this chapter for more information on this type of billing.)

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare links payment of the administration of the pneumococcal vaccine to payment for services under the Medicare Physician Fee Schedule (MPFS), but does not actually reimburse under the MPFS. The payment for the administration is the lesser of the actual charge or the MPFS amount for a comparable injection. Since the MPFS amount is adjusted for each Medicare payment locality, payment for the administration of the vaccine varies by locality.

Medicare Physician Fee Schedule (MPFS) Information

For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Participating Providers

- Participating institutional providers and physicians, providers, and suppliers that accept assignment must bill Medicare if they charge a fee to pay any or all costs related to the provision and/or administration of the pneumococcal vaccine. They may not collect payment from beneficiaries.

Non-Participating Providers

- Physicians, providers, and suppliers who do not accept assignment may never advertise the service as free since the beneficiary incurs an out-of-pocket expense after Medicare has paid 100 percent of the Medicare-allowed amount.
- Non-participating physicians, providers, and suppliers who do not accept assignment on the **administration** of the vaccine may collect payment from the beneficiary, but they **must submit an unassigned claim on the beneficiary's behalf**. All physicians, qualified non-physician practitioners, and suppliers must accept assignment for the Medicare vaccine payment rate and may not collect payment from the beneficiary for the **vaccine**.
- The limiting charge provision does not apply to the pneumococcal vaccine benefit. Non-participating physicians and suppliers who do not accept assignment for the administration of the pneumococcal 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. When non-participating physicians or suppliers provide the services, the beneficiary is responsible for paying the difference between what the physician or supplier charges and the amount Medicare allows for the **administration** fee. **However, all physicians and suppliers, regardless of participation status, must accept assignment of the Medicare vaccine payment rate and may not collect payment from the beneficiary for the vaccine.**
- The five percent payment reduction for physicians who do not accept assignment does not apply to the administration of the pneumococcal vaccine. Only items and services covered under limiting charge are subject to the five percent payment reduction.

No Legal Obligation to Pay

- Non-Governmental Entities – Non-governmental entities (providers, physicians, suppliers) that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide

the immunizations free of charge to Medicare beneficiaries and may not bill Medicare.

- ○ Physicians may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients.
- ○ When an employer offers free vaccinations to its employees, the employer must offer the free vaccination to an employee who is also a Medicare beneficiary. The employer does not have to offer free vaccinations to its non-Medicare employees.
- ○ However, non-governmental entities that do not charge patients who are unable to pay or reduce their charge for patients of limited means (sliding fee scale), but do expect to be paid if a patient has health insurance that covers the services provided, may bill Medicare and expect payment.

- State and Local Governmental Entities – Governmental entities such as public health clinics, may bill Medicare for the pneumococcal vaccine administered to Medicare beneficiaries when services are provided free of charge to non-Medicare patients.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the pneumococcal **vaccine** depends on the type of facility providing the service. Table 9 lists the type of payment that facilities receive for the pneumococcal vaccine.

Table 9 – Facility Types, TOBs, and Payment Methodology for Pneumococcal Vaccine*

Facility Type	Type of Bill	Basis of Payment
Hospital, other than Indian Health Service (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Reasonable cost
IHS Hospital	12X, 13X	95% of Average Wholesale Price (AWP)
IHS CAH	85X	95% of AWP
Skilled Nursing Facility (SNF)	22X, 23X	Reasonable cost
Home Health Agency (HHA)	34X	Reasonable cost
Independent Renal Dialysis Facility (RDF)	72X	95% of AWP
Hospital-Based RDF	72X	Reasonable cost
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	95% of AWP
CAH Method I and Method II	85X	Reasonable cost

***NOTE:** RHCs and FQHCs are not included in this table since they do not report charges for a pneumococcal vaccination on their claims. Costs for the pneumococcal vaccination are included in the cost report, no line items are billed, and payment for the vaccine is made via the cost report at cost settlement. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website.

Medicare reimbursement for the **administration** of the pneumococcal vaccine depends on the type of facility providing the service. Table 10 lists the type of payment that facilities receive for the administration of the pneumococcal vaccine.

Table 10 – Facility Types, TOBs, and Payment Methodology for Administration of Pneumococcal Vaccine*

Facility Type	Type of Bill	Basis of Payment
Hospital, other than Indian Health Service (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS 94% of submitted charges for Maryland hospitals under the jurisdiction of the Health Services Cost Review Commission (HSCRC)
IHS Hospital	12X, 13X	Medicare Physician Fee Schedule (MPFS) amount associated with CPT code 90471
IHS CAH	85X	MPFS amount associated with CPT code 90471
Skilled Nursing Facility (SNF)	22X, 23X	MPFS amount associated with CPT code 90471
Home Health Agency (HHA)	34X	OPPS
Independent Renal Dialysis Facility (RDF)	72X	MPFS amount associated with CPT code 90471
Hospital-Based RDF	72X	Reasonable cost
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	MPFS amount associated with CPT code 90471
CAH Method I and Method II	85X	Reasonable cost

***NOTE:** RHCs and FQHCs are not included in this table since they do not report charges for a pneumococcal vaccination on their claims. Costs for the pneumococcal vaccination are included in the cost report, no line items are billed, and payment for the vaccine is made via the cost report at cost settlement. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website.

Outpatient Prospective Payment System (OPPS) Information

For more information about OPPS, visit http://www.cms.gov/HospitalOutpatientPPS on the CMS website.

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Reasons for Claim Denial

Medicare providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. Refer to the most current listing of these codes at http://www.wpc-edi.com/Codes on the Internet.

Providers can obtain additional information about claims from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Hepatitis B Virus (HBV) Vaccine

Hepatitis B is a serious disease caused by the hepatitis B virus (HBV). The virus can affect people of all ages. Hepatitis B attacks the liver and can cause chronic (life-long) infection, resulting in cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. The virus is found in the blood and body fluids of infected people and can be spread through sexual contact; the sharing of needles, other drug paraphernalia, and razors; tattoos or body piercing; from a mother to her infant during birth; and by living in a household with a chronically infected person. Hepatitis B can be prevented with the vaccine. Medicare provides coverage of the hepatitis B vaccine and its administration for certain beneficiaries at intermediate to high risk for HBV.

Dosage Information

Scheduled doses of the hepatitis B vaccine are required to provide complete protection to an individual.

Coverage Information

Medicare provides coverage for the hepatitis B vaccine and its administration for beneficiaries at intermediate or high risk of contracting HBV. Medicare requires that the hepatitis B vaccine be administered under a physician's order with supervision.

Reminder

Hepatitis B vaccine plus its administration are covered Part B benefits. Note that hepatitis B vaccine is **not** a Part D covered drug.

High-risk groups currently identified include:

- Individuals with End-Stage Renal Disease (ESRD),
- Individuals with hemophilia who received Factor VIII or IX concentrates,
- Clients of institutions for the developmentally disabled,
- Individuals who live in the same household as an HBV carrier,
- Homosexual men, and
- Illicit injectable drug users.

Intermediate risk groups currently identified include:

- Staff in institutions for the developmentally disabled, and
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

Exception: **Persons in the above-listed groups would not be considered at high or intermediate risk of contracting HBV infection if they have laboratory evidence positive for antibodies to HBV. (ESRD patients are routinely tested for HBV antibodies as part of their continuing monitoring and therapy.)**

Stand Alone Benefit

The hepatitis B vaccine covered by Medicare is a stand alone billable service separate from the Initial Preventive Physical Examination (IPPE) and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

Medicare provides coverage for the hepatitis B vaccine as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

NOTE: The Medicare Part B deductible does not apply to Federally Qualified Health Centers (FQHCs).

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, listed in Table 11, must be used to report hepatitis B vaccination. Providers may list charges for other services on the same bill as the hepatitis B vaccine; however, the applicable codes for the additional services must be used.

Table 11 – HCPCS/CPT Codes for Hepatitis B Vaccine and Administration

HCPCS/CPT Code	Code Descriptor
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
G0010	Administration of Hepatitis B vaccine

***NOTE:** Outpatient Prospective Payment System (OPPS) hospitals report HCPCS code G0010 for hepatitis B vaccine administration.

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Diagnosis Requirements

Medicare providers must report the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code, listed in Table 12.

If the **sole** purpose of the visit was to receive the hepatitis B vaccine or if the hepatitis B vaccine is the only service billed on a claim, ICD-9-CM diagnosis code V05.3 must be reported.

Table 12 – Diagnosis Code for Hepatitis B Vaccination

ICD-9-CM Diagnosis Code	Code Descriptor
V05.3	Need for prophylactic vaccination and inoculation against single diseases; Viral hepatitis

Billing Requirements

General Requirements

- All billers using the X12 837 Institutional electronic claim format (or Form CMS-1450) and the X12 837 Professional electronic claim format (or Form CMS-1500) should note that all data fields required for any institutional or professional claim are also required for the vaccines and their administration. Medicare providers should bill in accordance with the instructions within provider manuals provided by the carrier/AB Medicare Administrative Contractor (carrier/AB MAC). Additionally, coding specific to these benefits is required.
- Medicare providers and suppliers are responsible for completing required items on the claim forms with correct information obtained from the beneficiary.
- If a physician provides other Medicare-covered services during the visit in which the immunization is given, the physician may code and bill those other medically necessary services, including Evaluation and Management (E/M) services. Refer to the "Documentation Guidelines for Evaluation and Management Services" for 1995 and 1997 at http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Billing and Coding Requirements When Submitting Claims to Carriers/AB MACs

Medicare requires that the hepatitis B vaccination be administered under a physician's order with supervision. Because of this requirement, the ordering and/or referring physician information must be reported on the claim.

In addition, when physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS code for the administration of the hepatitis B vaccine (G0010), the appropriate CPT vaccine code (90740, 90743, 90744, 90746, or 90747), and the corresponding ICD-9-CM diagnosis code (V05.3) in the X12 837 Professional electronic claim format.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT code for the administration of the hepatitis B vaccine (G0010, 90471, or 90472), the appropriate CPT vaccine code (90740, 90743, 90744, 90746, or 90747), the appropriate revenue code (0636 or 0771), and the corresponding ICD-9-CM diagnosis code (V05.3) in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for hepatitis B vaccination services when submitted on the following TOBs and associated revenue codes, listed in Table 13.

Table 13 – Facility Types, TOBs, and Revenue Codes for Hepatitis B Vaccination*

Facility Type	Type of Bill	Revenue Code
Hospital, other than Indian Health Service (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	0636 – vaccine 0771 – administration
IHS Hospital	12X, 13X	0636 – vaccine 0771 – administration
IHS CAH	85X	0636 – vaccine 0771 – administration
Skilled Nursing Facility (SNF) Inpatient Part B**	22X	0636 – vaccine 0771 – administration
SNF Outpatient	23X	0636 – vaccine 0771 – administration
Home Health Agency (HHA)***	34X	0636 – vaccine 0771 – administration
Independent and Hospital-Based Renal Dialysis Facility (RDF)	72X	0636 – vaccine 0771 – administration
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0636 – vaccine 0771 – administration

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Facility Type	Type of Bill	Revenue Code
CAH Method I and II****	85X	0636 – vaccine 0771 – administration

***NOTE:** Rural Health Clinics (RHCs) and FQHCs are not included in this table since payment for the hepatitis B vaccine and its administration are included in the all-inclusive encounter rate. RHCs and FQHCs do not bill for a visit when the only service provided is the administration of the hepatitis B vaccine. If the sole reason for the visit is to receive the hepatitis B vaccine, the cost can be included on a claim for the beneficiary's subsequent visit. If other services, which constitute a qualifying RHC or FQHC visit, are provided at the same time as the hepatitis B vaccination, the cost of the vaccine and its administration are included on the claim for the current visit. All charges for the visit and the hepatitis B vaccine and its administration must be combined on the same line under revenue code 052X and TOB 71X or 77X, respectively. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website.

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for hepatitis B vaccination and its administration for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Hepatitis B vaccination and its administration provided by other facility types must be reimbursed by the SNF.

*****NOTE:** Medicare will not pay for a skilled nursing visit by an HHA nurse under the home health benefit when the sole purpose for an HHA visit is to administer a vaccine (seasonal influenza virus, pneumococcal, or hepatitis B). However, the vaccine and its administration are covered under the home health benefit. The administration should include charges only for the supplies being used and the cost of the injection. HHAs are not permitted to charge for travel time or other expenses (e.g., gasoline).

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

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

Additional Billing Instructions

- **Other Charges** – Other charges may be listed on the same bill; however, the Medicare provider must include the applicable codes for the additional charges.
- **Certified Part A Providers** – With the exception of hospice providers, certified Part A providers must bill the FI/AB MAC for the Part B benefit.
- **Hospice Providers** – Hospice providers must bill the carrier/AB MAC using the X12 837 Professional electronic claim format (or Form CMS-1500).
- **Non-Medicare Participating Providers** – Non-Medicare participating provider facilities must bill the local carrier/AB MAC.
- **HHAs** – HHAs that have a Medicare-certified component and a non-Medicare certified component may elect to furnish the hepatitis B vaccination through the non-certified component and bill the carrier/AB MAC.
- **Hospitals** – Hospitals must bill the FI/AB MAC for inpatient vaccination.
- **RHCs and FQHCs** – For RHCs and FQHCs, payment for the hepatitis B vaccine and its administration

are included in the all-inclusive encounter rate. RHCs and FQHCs do not bill for a visit when the only service provided is the administration of the hepatitis B vaccine. If the sole reason for the visit is to receive the hepatitis B vaccine, the cost can be included on a claim for the beneficiary's subsequent visit. If other services, which constitute a qualifying RHC or FQHC visit, are provided at the same time as the hepatitis B vaccination, the cost of the vaccine and its administration are included on the claim for the current visit. All charges for the visit and the hepatitis B vaccine and its administration must be combined on the same line under revenue code 052X and TOB 71X or 77X. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website.

- **Dialysis Patients** – On claims for a dialysis patient of a hospital or hospital-based renal dialysis facility, the hospital bills the FI/AB MAC.

Reimbursement Information

General Information

Medicare provides coverage for the hepatitis B vaccine as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived for the vaccine. However, the beneficiary may incur a coinsurance or copayment for the administration of the vaccine if the provider does not accept assignment.

National Correct Coding Initiative (NCCI) Edits

Refer to the currently applicable bundled carrier processed procedures at http://www.cms.gov/NationalCorrectCodInitEd on the CMS website.

NOTE: The Medicare Part B deductible does not apply to FQHC services.

All Medicare providers of the hepatitis B vaccine must accept assignment for the **vaccine**. It is not mandatory for Medicare providers to accept assignment for the **administration** of the hepatitis B vaccine.

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses the vaccine and its administration under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all hepatitis B vaccine services.

Medicare Physician Fee Schedule (MPFS) Information

For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

No Legal Obligation to Pay

- Non-Governmental Entities – Non-governmental entities (providers, physicians, suppliers) that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare.
    - Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients.
    - When an employer offers free vaccinations to its employees, the employer must also offer the free vaccination to an employee who is also a Medicare beneficiary. The employer does not have to offer free vaccinations to its non-Medicare employees.

  - ○ However, non-governmental entities that do not charge patients who are unable to pay or reduce their charge for patients of limited means (sliding fee scale), but do expect to be paid if a patient has health insurance that covers the services provided, may bill Medicare and expect payment.
- State and Local Governmental Entities – Governmental entities, such as public health clinics, may bill Medicare for the hepatitis B vaccine administered to Medicare beneficiaries when services are provided free of charge to non-Medicare patients.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the hepatitis B **vaccine** depends on the type of facility providing the service. Table 14 lists the type of payment that facilities receive for the hepatitis B vaccine.

Table 14 – Facility Types, TOBs, and Payment Methodology for Hepatitis B Vaccine*

Facility Type	Type of Bill	Basis of Payment
Hospital, other than Indian Health Service (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Reasonable cost
IHS Hospital	12X, 13X	95% of Average Wholesale Price (AWP)
IHS CAH	85X	95% of AWP
Skilled Nursing Facility (SNF)	22X, 23X	Reasonable cost
Home Health Agency (HHA)	34X	Reasonable cost
Independent Renal Dialysis Facility (RDF)	72X	95% of AWP
Hospital-Based RDF	72X	Reasonable cost
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	95% of AWP
CAH Method I and Method II	85X	Reasonable cost

***NOTE:** RHCs and FQHCs are not included in this table since payment for the hepatitis B vaccine and its administration are included in the all-inclusive encounter rate. RHCs and FQHCs do not bill for a visit when the only service provided is the administration of the hepatitis B vaccine. If the sole reason for the visit is to receive the hepatitis B vaccine, the cost can be included on a claim for the beneficiary's subsequent visit. If other services, which constitute a qualifying RHC or FQHC visit, are provided at the same time as the hepatitis B vaccination, the cost of the vaccine and its administration are included on the claim for the current visit. All charges for the visit and the hepatitis B vaccine and its administration must be combined on the same line under revenue code 052X and TOB 71X or 77X. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website.

Medicare reimbursement for the **administration** of the hepatitis B vaccine depends on the type of facility providing the service. Table 15 lists the type of payment that facilities receive for the administration of the hepatitis B vaccine.

Table 15 – Facility Types, TOBs, and Payment Methodology for Hepatitis B Vaccine Administration*

Facility Type	Type of Bill	Basis of Payment
Hospital, other than Indian Health Service (IHS) Hospital and Critical Access Hospital (CAH)	12X, 13X	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS 94% of submitted charges for Maryland hospitals under the jurisdiction of the Health Services Cost Review Commission (HSCRC)
IHS Hospital	12X, 13X	Medicare Physician Fee Schedule (MPFS) amount associated with CPT code 90471
IHS CAH	85X	MPFS amount associated with CPT code 90471
Skilled Nursing Facility (SNF)	22X, 23X	MPFS amount associated with CPT code 90471
Home Health Agency (HHA)	34X	OPPS
Independent Renal Dialysis Facility (RDF)	72X	MPFS amount associated with CPT code 90471
Hospital-Based RDF	72X	Reasonable cost
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	MPFS amount associated with CPT code 90471
CAH Method I and Method II	85X	Reasonable cost

***NOTE:** RHCs and FQHCs are not included in this table since payment for the hepatitis B vaccine and its administration are included in the all-inclusive encounter rate. RHCs and FQHCs do not bill for a visit when the only service provided is the administration of the hepatitis B vaccine. If the sole reason for the visit is to receive the hepatitis B vaccine, the cost can be included on a claim for the beneficiary's subsequent visit. If other services, which constitute a qualifying RHC or FQHC visit, are provided at the same time as the hepatitis B vaccination, the cost of the vaccine and its administration are included on the claim for the current visit. All charges for the visit and the hepatitis B vaccine and its administration must be combined on the same line under revenue code 052X and TOB 71X or 77X. RHCs and FQHCs should refer to the guidelines in the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 9, Section 120 at http://www.cms.gov/manuals/downloads/clm104c09.pdf on the CMS website.

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Reasons for Claim Denial

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

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

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Mass Immunizers/Roster Billers

"Mass Immunizer" Overview

A "mass immunizer," as used by the Centers for Medicare & Medicaid Services (CMS), is defined as a Medicare provider who generally offers seasonal influenza virus and/or pneumococcal vaccinations to a large number of individuals; for example, the general public or members of a specific group, such as residents of a retirement community. A mass immunizer may be a traditional Medicare provider or supplier, such as a hospital outpatient department, or may be a non-traditional provider or supplier, such as a senior citizens' center, a public health clinic, a community pharmacy, or a supermarket. Mass immunizers submit claims for immunizations on roster bills and must accept assignment. A mass immunizer is a provider type created under Medicare specifically to facilitate mass immunization, not to provide other services.

NOTE: Medicare has not developed roster billing for hepatitis B virus (HBV) vaccinations.

Enrollment Requirements

This enrollment process currently applies **only** to entities that enroll with Medicare as a "Mass Immunization Roster Biller." These entities will perform the following functions:

1. Bill a carrier/AB Medicare Administrative Contractor (carrier/AB MAC).
2. Use roster bills.
3. Bill only for seasonal influenza virus and/or pneumococcal vaccinations.
4. Accept assignment on both the vaccines and their administration.

Form CMS-1500

All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Whether an entity enrolls as a provider type "Mass Immunization Roster Biller" or some other type of provider, the entity must follow all normal enrollment processes and procedures. Authorization from the

CMS Central Office (CO) to participate in centralized billing is dependent upon the entity's ability to qualify as some type of Medicare provider. Entities must be properly licensed in the states in which they plan to operate.

Medicare providers and suppliers must enroll in the Medicare Program even if mass immunizations are the only service they will provide to Medicare beneficiaries. Entities providing mass immunizations must enroll by completing Form CMS-855I for individuals or Form CMS-855B for groups. Providers and suppliers who wish to roster bill for mass immunizations should contact the carrier/AB MAC servicing their area for a copy of the enrollment application and instructions for mass immunizers. Refer to the list of carriers/AB MACs and their contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website. Refer to the enrollment applications at http://www.cms.gov/MedicareProviderSupEnroll on the CMS website.

Medicare providers and suppliers who wish to bill for other Medicare Part B services must enroll as a regular provider or supplier by completing the entire Form CMS-855I for individuals or the Form CMS-855B for groups. Although CMS wants to make it as easy as possible for providers and suppliers to immunize Medicare beneficiaries and bill Medicare, it must ensure that those providers who wish to enroll in the Medicare Program are qualified providers, receive a provider ID number, and receive payment.

Roster Billing Procedures

Mass Immunizer Roster Billing

Roster billing is a streamlined process for submitting health care claims for large groups of beneficiaries for seasonal influenza virus and/or pneumococcal vaccinations. Roster billing can be done electronically or by paper. Mass immunizers should contact their carrier/AB MAC for information on electronic roster billing.

General Information

Individuals and entities submitting paper claims for seasonal influenza virus and pneumococcal vaccinations must submit a separate Form CMS-1450 or Form CMS-1500 for each type of vaccination. Each Form CMS-1450 or Form CMS-1500 must have an attached roster bill listing the beneficiaries who received that type of vaccination. Each roster bill must also contain all other information required on a roster bill.

For inpatient/outpatient departments of hospitals and outpatient departments of other providers that roster bill, a "signature on file" stamp or notation qualifies as an actual signature on the roster claim form if the provider has access to a signature on file in the beneficiary's record. In this situation, the provider is not required to obtain the beneficiary's signature on the roster. A "signature on file" is acceptable for entities that bill Fiscal Intermediaries (FIs)/AB MACs and/or carriers/AB MACs.

Roster Billing and Paper Claims

Paper claims for roster billing of Medicare-covered vaccinations are exempt from the electronic billing requirement under a Final Rule published in the Federal Register on November 25, 2005. Refer to the ruling at http://www.gpo.gov/fdsys/pkg/FR-2005-11-25/pdf/05-23080.pdf on the Internet.

Roster Billing Institutional Claims

Generally, for institutional claims (claims submitted to FIs/AB MACs for processing) only, providers must vaccinate at least five beneficiaries per day to roster bill. However, this requirement is waived for inpatient hospitals that mass immunize and use the roster billing method.

Medicare will pay for both the seasonal influenza virus and pneumococcal vaccines above the Diagnosis-Related Group (DRG) rate for beneficiaries vaccinated during hospitalization. Hospitals may roster bill for both vaccines using Type of Bill (TOB) 12X. Vaccines billed on TOB 11X will not be paid. Both the coinsurance or copayment and the Medicare Part B deductible are waived.

Roster Billing Part B Claims

Providers and suppliers submitting Part B claims to carriers/AB MACs for processing are **not** required to immunize at least five beneficiaries on the same date for an individual or entity to qualify for roster billing. However, the rosters should not be used for single beneficiary bills, and the date of service for each vaccination administered must be entered.

Modified Form CMS-1500 (08-05)

Medicare providers who qualify to roster bill may use a preprinted Form CMS-1500.

The following blocks, listed in Table 16, can be preprinted on a modified Form CMS-1500, which serves as the cover document for the roster, for entities using roster billing for seasonal influenza virus vaccine, pneumococcal vaccine, and/or administration claims submitted to carriers/AB MACs.

Table 16 – Preprinted Information on Form CMS-1500

Form CMS-1500 Blocks	Preprinted Information
Item 1:	Enter an “X” in the Medicare block.
Item 2:	(Patient’s Name): Enter “SEE ATTACHED ROSTER”.
Item 11:	(Insured’s Policy Group or Federal Employees’ Compensation Act [FECA] Number): Enter “NONE”.
Item 20:	(Outside Lab?): Enter an “X” in the “NO” block.
Item 21:	(Diagnosis or Nature of Illness): Line 1: Enter appropriate diagnosis code.
Item 24B:	(Place of Service [POS]): Line 1: Enter “60”. Line 2: Enter “60”. **NOTE:** POS code “60” must be used for roster billing.

Form CMS-1500 Blocks	Preprinted Information
Item 24D:	(Procedures, Services, or Supplies): Line 1: Pneumococcal Vaccine: Enter “90732” or Seasonal Influenza Virus Vaccine: Enter appropriate seasonal influenza virus vaccine code. Line 2: Pneumococcal Vaccine Administration: Enter “G0009” or Seasonal Influenza Virus Vaccine Administration: Enter “G0008”.
Item 24E:	(Diagnosis Code): Lines 1 and 2: Enter “1”.
Item 24F:	($ Charges): Enter the charge for each listed service. If you are not charging for the vaccine or its administration, enter “0.00” or “NC” (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC pneumococcal or seasonal influenza virus vaccine claims only if your system is able to accept them.
Item 27:	(Accept Assignment): Enter an “X” in the YES block.
Item 29:	(Amount Paid): Enter “$0.00”.
Item 31:	(Signature of Physician or Supplier): The entity’s representative must sign the modified Form CMS-1500 (08-05).
Item 32:	Enter the name, address, and ZIP code of the location where the service was provided (including centralized billers).
Item 32a:	Enter the National Provider Identifier (NPI) of the service facility.
Item 33:	(Physician’s, Supplier’s Billing Name): Enter the Provider Identification Number (not the Unique Physician Identification Number) or NPI when required.
Item 33a:	Enter the NPI of the billing provider or group.

Medicare providers must submit separate Form CMS-1500 claim forms along with separate roster bills for seasonal influenza virus and pneumococcal vaccine roster billing.

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Roster Claim Form

Medicare providers must include the following information on a beneficiary roster form to attach to a preprinted Form CMS-1500 under the roster billing procedure:

- Provider name and National Provider Identifier (NPI) number,
- Date of service,

  NOTE: Although physicians who provide pneumococcal or seasonal influenza virus vaccinations may roster bill if they vaccinate fewer than five beneficiaries per day, they must include the individual date of service for each beneficiary's vaccination on the roster form.
- Control number for the contractor,
- Beneficiary's Health Insurance Claim Number (HICN),
- Beneficiary's name,
- Beneficiary's address,
- Beneficiary's date of birth,
- Beneficiary's sex, and
- Beneficiary's signature or stamped "signature on file."

Some carriers/AB MACs allow providers and suppliers to develop their own roster forms that contain the minimum data listed above, while others do not. Please contact the carrier/AB MAC to learn its particular practice regarding roster forms.

NOTE: A stamped "signature on file" qualifies as an actual signature on a roster claim form if the provider has a signed authorization on file to bill Medicare for services provided. In this situation, the provider is not required to obtain the beneficiary signature on the roster, but instead has the option of reporting "signature on file" in lieu of obtaining the beneficiary's actual signature.

Required Language for Pneumococcal Vaccine Rosters

The roster bills used for influenza virus and pneumococcal vaccinations are not identical. The pneumococcal roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering pneumococcal vaccination:

WARNING: Beneficiaries must be asked if they have received a pneumococcal vaccination.

- Rely on patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past five years, administer the vaccine.
- If patients are certain that they have been vaccinated within the past five years, do not revaccinate.

Other Covered Services

Medicare providers may not list other covered services with the seasonal influenza virus and/or pneumococcal vaccine and administration on the modified Form CMS-1500. Other covered services are subject to more comprehensive data requirements that the roster billing process is not designed to accommodate. Providers must bill other services using normal Medicare Part B claims filing procedures and forms.

Jointly Sponsored Vaccination Clinics

In some instances, two entities, such as a grocery store and a pharmacy, jointly sponsor a seasonal influenza virus or pneumococcal vaccination clinic. Assuming that charges are made for the vaccine and

its administration, the entity that furnishes the vaccine and the entity that administers the vaccine are each required to submit claims. Both parties **must** file separately for the specific component furnished for which a charge was made.

When billing only for the administration, billers must indicate in block 24 of Form CMS-1500 that they did not furnish the vaccine. For roster-billed claims, this can be accomplished by lining through the preprinted block 24 line item component that was not furnished by the billing entity or individual.

Centralized Billing

NOTE: This section applies only to those individuals and entities that will provide mass immunization services for seasonal influenza virus and pneumococcal vaccinations and that have been authorized by CMS to centrally bill.

Centralized Billing Overview

Centralized billing is an optional program available to providers who qualify to enroll with Medicare as provider type "Mass Immunization Roster Biller," as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billing is a process in which a Medicare provider, who is a mass immunizer for seasonal influenza virus and pneumococcal immunizations, can send all its seasonal influenza virus and pneumococcal immunization claims to a single carrier/AB MAC for payment, regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers, or Indian Health Service. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the seasonal influenza virus and pneumococcal vaccines and their administration. Currently, CMS authorizes only a limited number of Medicare providers to centrally bill for seasonal influenza virus and pneumococcal immunization claims.

Centralized Billers Must Roster Bill, Accept Assignment, and Bill Electronically

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers/AB MACs processing claims. Individuals and entities providing vaccines and administration of vaccines must be properly licensed in the state(s) in which the immunizations are given. It is the responsibility of the provider to ensure it meets the licensure/certification requirements in the states where it plans to operate vaccination clinics.

Payment Rates and Mandatory Assignment

The payment rates for the administration of the vaccinations are based on the Medicare Physician Fee Schedule (MPFS) for the appropriate year. The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals, which is the lower of cost or 95 percent of the Average Wholesale Price (AWP).

All providers of pneumococcal and seasonal influenza virus vaccines must accept assignment for the vaccine. In addition, as a requirement for centralized billing and roster billing, Medicare providers must also agree to accept assignment for the administration of the vaccines. Thus, centralized billers and roster billers must agree to accept the amount that Medicare pays for the vaccine and the administration. Since the coinsurance or copayment and Medicare Part B deductible are waived for the seasonal influenza virus and pneumococcal vaccine benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccinations.

Centralized Billing Program Enrollment

Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the processing carrier/AB MAC for centralized billing through completion of Form CMS-855 (Medicare Enrollment Application).

Participation in the Centralized Billing Program

Individuals and entities interested in centralized billing must contact the CMS CO, in writing, at the following address:

The Centers for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop C4-10-07
Baltimore, Maryland 21244

Medicare providers and suppliers are encouraged to apply to enroll as a centralized biller early, as the enrollment process takes 8-12 weeks to complete. Applicants who have not completed the entire enrollment process and received approval from the CMS CO and the designated carrier/AB MAC to participate as a Medicare mass immunizer centralized biller will not be allowed to submit claims to Medicare for reimbursement.

Required Information

The information below must be included with the individual or entity's written request to participate in centralized billing:

- Estimates for the number of beneficiaries who will receive seasonal influenza virus vaccinations;
- Estimates for the number of beneficiaries who will receive pneumococcal vaccinations;
- The approximate dates for when the vaccinations will be given;
- A list of the states in which the seasonal influenza virus and pneumococcal vaccination clinics will be held;
- The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse);
- Whether the nurses who will administer the seasonal influenza virus and pneumococcal vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering seasonal influenza virus and pneumococcal vaccinations;
- Names and addresses of all entities operating under the corporation's application; and
- Contact information for the designated contact person for the centralized billing program.

NOTE: Approval for centralized billing is limited to the 12-month period from September 1 through August 31 of the following year. It is the responsibility of centralized billers to reapply to CMS CO for approval each year by June 1.

Up Front Beneficiary Payment Is Inappropriate

The practice of requiring a beneficiary to pay for the vaccination up front and to file his or her own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per Section 1848(g)(4)(A) of the Social Security Act, and centralized billers may not collect any payment from beneficiaries.

Planning a Flu Vaccination Clinic

The following is being provided for informational purposes as a general guide. The issues involved in planning and administering a flu vaccination clinic can be complex and may vary from state to state. We encourage Medicare providers, suppliers, and immunizers to become familiar with relevant laws, regulations, and policies before planning and administering a flu vaccination clinic.

Table 17 provides a calendar of a sample schedule planners of flu vaccination clinics may consider.

Table 17 – Flu Vaccination Clinic Calendar

Month	Activity
January	Create a planning committee: • Determine roles and responsibilities, • Determine staffing levels needed, and • Decide location(s) of vaccination clinic.
February	Hold a planning committee meeting: • Determine clinic layout and specifications, and • Determine how to advertise the clinic.
March	Hold a planning committee meeting: • Coordinate with other flu vaccination clinics in geographical area, and • Gather information on latest vaccine recommendations (visit http://www.cdc.gov/flu on the Internet).
April	Order vaccines.
May	Determine dates of flu vaccination clinic(s): • Consider conducting flu vaccination clinics in October and/or November; and • Consider offering a flu vaccination clinic in December or January, even after influenza activity has been documented in your community.
June	Register your flu vaccination clinic on the flu clinic locator website (visit http://www.lungusa.org/lung-disease/influenza/flu-vaccine-finder on the Internet).
July	Decide how many nurses and clerks will need to be hired on a temporary basis to administer the shots and submit the claims.
August	Send letters and/or e-mails to retirement communities, churches, municipal buildings, and other locations throughout the community offering to set up a flu vaccination clinic at their site (for sample letters, visit http://www.lungusa.org/lung-disease/influenza/flu-vaccine-finder on the Internet).
September	Begin advertising flu vaccination dates, times, and locations (for sample posters, visit http://www.lungusa.org/lung-disease/influenza/flu-vaccine-finder on the Internet).
October	Conduct clinic(s).

Month	Activity
November	Conduct clinic(s).
December	Conduct clinic(s).
Beyond December	Protection can still be obtained if the seasonal influenza vaccine is given in December or later. Continue to provide the seasonal influenza vaccine as long as you have vaccine available, even after the new year.

Flu Vaccination Clinic Supplies Checklist

Essential items for a flu vaccination clinic include the following:

- Vaccine vials,
- Anaphylaxis kits,
- Alcohol wipes,
- Band-Aids,
- Sharps containers,
- Safety syringes/needles,
- Boxes of gloves,
- Nurse's kit,
- Cash box, and
- Confidentiality folder.

More Information

For additional strategies that health care professionals can implement that may help increase seasonal influenza vaccination rates, visit the following Centers for Disease Control and Prevention (CDC) web pages:

- Strategies for Increasing Adult Seasonal Influenza Vaccination Rates
  http://www.cdc.gov/vaccines/recs/reminder-sys.htm
- CDC Guidelines for Large-Scale Seasonal Influenza Vaccination Clinic Planning
  http://www.cdc.gov/flu/professionals/vaccination/vax_clinic.htm
- CDC Vaccines and Immunizations website for Health Care Professionals
  http://www.cdc.gov/vaccines/hcp.htm

Seasonal Influenza, Pneumococcal, and Hepatitis B Virus Vaccinations

Resources

"2010-2011 Immunizers' Question & Answer Guide to Medicare Part B & Medicaid Coverage of Seasonal Influenza and Pneumococcal Vaccinations"
http://www.cms.gov/AdultImmunizations/Downloads/20102011ImmunizersGuide.pdf

Advisory Committee on Immunization Practices Website
http://www.cdc.gov/vaccines/recs/acip

American Lung Association Flu Clinic Locator
http://www.lungusa.org/lung-disease/influenza/flu-vaccine-finder

American Lung Association – Influenza
http://www.lungusa.org/lung-disease/influenza

American Lung Association Influenza Fact Sheet
http://www.lungusa.org/lung-disease/influenza/in-depth-resources/influenza-fact-sheet.html

American Lung Association – Pneumonia
http://www.lungusa.org/lung-disease/pneumonia

CDC Hepatitis B Vaccination
http://www.cdc.gov/vaccines/vpd-vac/hepb

CDC Pneumococcal Vaccination
http://www.cdc.gov/vaccines/vpd-vac/pneumo

CDC Seasonal Flu Website
http://www.cdc.gov/flu

CDC Vaccines & Immunizations
http://www.cdc.gov/vaccines

CMS Adult Immunization Web Page
http://www.cms.gov/AdultImmunizations

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

Food and Drug Administration 2010-2011 Influenza Season Vaccine Questions and Answers
http://www.fda.gov/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/Post-MarketActivities/LotReleases/ucm220649.htm

Immunization Action Coalition
http://www.immunize.org

Know What to Do about the Flu
http://www.flu.gov

"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 50.4.4.2
http://www.cms.gov/manuals/Downloads/bp102c15.pdf

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 10
http://www.cms.gov/manuals/downloads/clm104c18.pdf

Medicare Learning Network® (MLN) Influenza (Flu) Season Educational Products and Resources
http://www.cms.gov/MLNProducts/Downloads/flu_products.pdf

MLN "Adult Immunizations" Brochure (ICN 006435)
http://www.cms.gov/MLNProducts/downloads/Adult_Immunization.pdf

MLN Matters® Article SE1031, "2010-2011 Seasonal Influenza (Flu) Resources for Health Care Professionals"
http://www.cms.gov/MLNMattersArticles/downloads/SE1031.pdf

MLN "Medicare Preventive Services Quick Reference Information: Medicare Immunization Billing (Seasonal Influenza, Pneumococcal, and Hepatitis B)" (ICN 006799)
http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf

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

National Alliance for Hispanic Health
Information on vaccines is available in both English and Spanish.
http://www.hispanichealth.org

National Center for Immunization and Respiratory Diseases
http://www.cdc.gov/ncird

National Foundation for Infectious Diseases
http://www.nfid.org

National Vaccine Program Office Website
http://www.hhs.gov/nvpo

Prevention and Control of Influenza
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5707a1.htm?s_cid=rr5707a1_e

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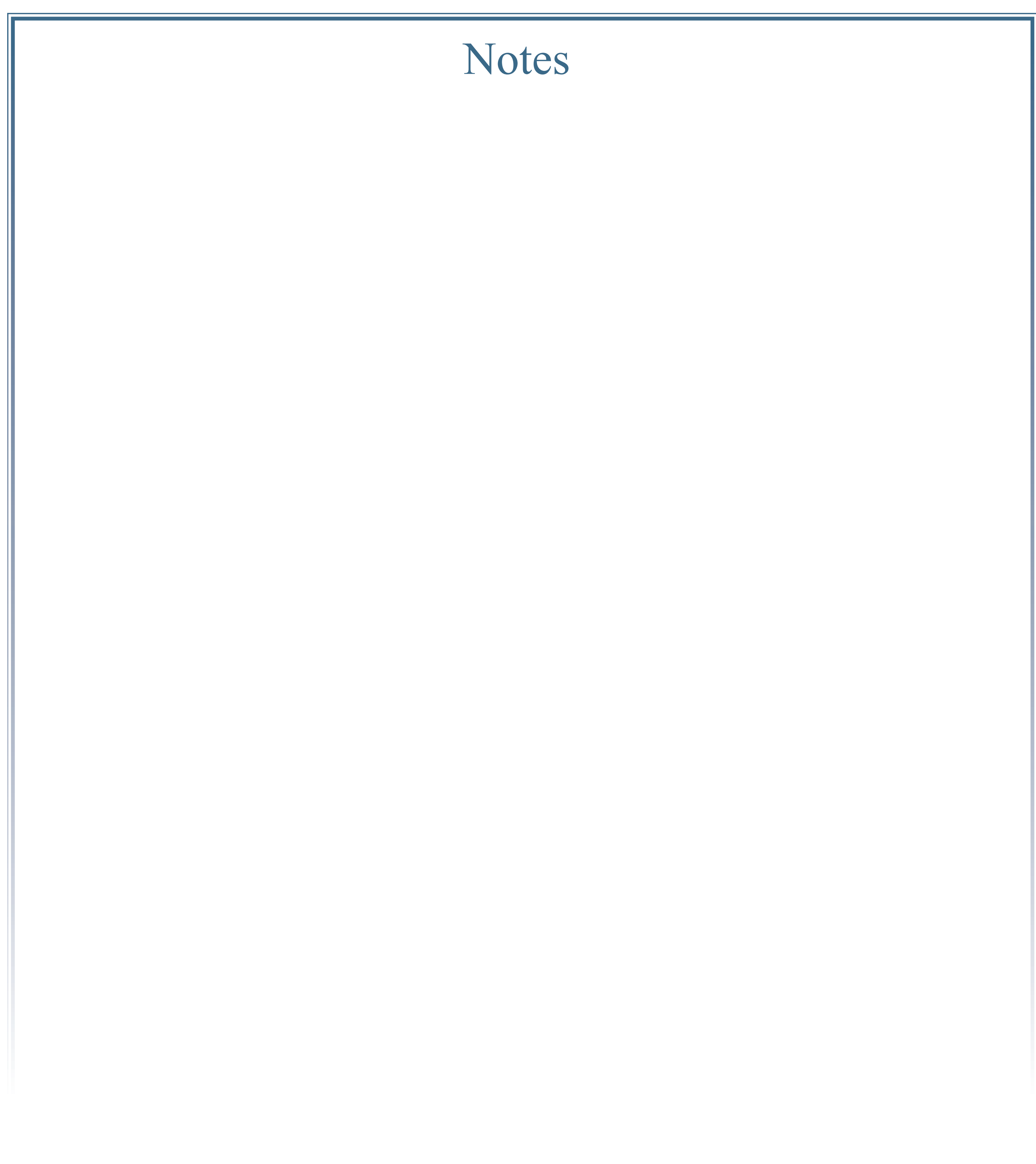
More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.


Notes

Chapter 6
Diabetes-Related Services

Overview

Millions of people have diabetes and don't know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, pregnancy complications, and death related to pneumonia and influenza. Diabetes is the leading cause of blindness among adults and the leading cause of End-Stage Renal Disease (ESRD).

The good news is that scientific evidence shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay many of the illnesses and complications associated with diabetes. Medicare coverage of preventive screening for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes helps 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.

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

The coinsurance or copayment and deductible for diabetes screening tests are already waived and are not affected by the Affordable Care Act.

The coinsurance or copayment and deductible apply for the Medical Nutrition Therapy (MNT) benefit. For dates of service on or after January 1, 2011, both are waived by the Affordable Care Act.

The Affordable Care Act does not affect the coinsurance or copayment or deductible for diabetes supplies or for Diabetes Self-Management Training (DSMT).

The Affordable Care Act revised the list of preventive care services paid by Medicare in the Federally Qualified Health Center (FQHC) setting. For dates of service on or after January 1, 2011, the professional components of diabetes screening tests, DSMT, and MNT will be covered FQHC services when provided by an FQHC.

Diabetes Mellitus

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

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

Pre-Diabetes

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

The diabetes screening tests covered by Medicare include the following:

- A fasting blood glucose test; and
- A post-glucose challenge test (including, but not limited to, an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults) or a 2-hour post-glucose challenge test alone.

Risk Factors

To be eligible for the diabetes screening tests, beneficiaries must have any of the following risk factors:

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

OR

At least two of the following characteristics:

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

Diabetes Screening Tests

Coverage Information

Medicare provides coverage of diabetes screening tests for beneficiaries in the risk groups previously listed or those diagnosed with pre-diabetes.

Medicare provides coverage of diabetes screening tests as a Medicare Part B benefit after a referral from a physician or qualified non-physician practitioner for a beneficiary at risk for diabetes.

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

Who Are Qualified Physicians and Non-Physician Practitioners?

Physician

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

Qualified Non-Physician Practitioner

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

Beneficiaries Diagnosed with Pre-Diabetes

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

Beneficiaries Previously Tested but not Diagnosed as Pre-Diabetic or Who Have Never Been Tested

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

Calculating Frequency

When calculating frequency to determine the 11-month period, the count starts beginning with the month after the month in which a previous test was performed.

Stand Alone Benefit

The diabetes screening benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

EXAMPLE: The beneficiary, previously tested but not diagnosed as pre-diabetic, received a diabetes screening test in January 2010. The count starts beginning February 2010. The beneficiary is eligible to receive another diabetes screening test in January 2011 (the month after 11 months have passed).

Coinsurance or Copayment and Deductible

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

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Current Procedural Terminology (CPT) codes, listed in Table 1, must be used to report diabetes screening tests.

Table 1 – CPT Codes for Diabetes Screening Tests

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

NOTE: Medicare makes payment for these procedure codes under the Clinical Laboratory Fee Schedule. To ensure that Medicare and Medicaid only pay for a laboratory test categorized as waived complexity under the Clinical Laboratory Improvement Amendments (CLIA), these CPT codes must be billed with modifier -QW to be recognized as a waived test.

Diagnosis Requirements

Medicare providers must report the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening (“V”) diagnosis code, listed in Table 2. When a Medicare provider submits a claim for diabetes screening where the beneficiary meets the definition of pre-diabetes, the appropriate diagnosis code with modifier -TS should be reported.

Table 2 – Diagnosis Code for Diabetes Screening

ICD-9-CM Diagnosis Code	Code Descriptor
V77.1	Special screening for diabetes mellitus

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Billing Requirements

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

When physicians or qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate CPT code and the corresponding ICD-9-CM diagnosis code(s) in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Claims Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate CPT code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code(s) in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for the diabetes screening tests when submitted on the following TOBs, listed in Table 3.

Table 3 – Facility Types and TOBs for Diabetes Screening Tests

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

Facility Type	Type of Bill
CAH Outpatient**	85X
Federally Qualified Health Center (FQHC) for dates of service on or after January 1, 2011	77X See Additional Billing Instructions for FQHCs
Rural Health Clinics (RHC)	71X See Additional Billing Instructions for RHCs

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for diabetes screening tests for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Diabetes screening tests provided by other facility types must be reimbursed by the SNF.

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

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

For dates of service on or after July 1, 2009, a CAH will be paid 101 percent of reasonable costs for outpatient clinical diagnostic laboratory tests, and the beneficiary is no longer required to be physically present in a CAH at the time the specimen is collected. However, the beneficiary must be an outpatient of the CAH and be receiving services directly from the CAH. In order for the beneficiary to be receiving services directly from the CAH, the beneficiary must be either receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or an entity that is provider-based to the CAH.

Additional Billing Instructions for RHCs

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

Additional Billing Instructions for FQHCs

Dates of Service Prior to January 1, 2011

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

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

Dates of Service on or After January 1, 2011

The Affordable Care Act revised the list of preventive services paid by Medicare in the FQHC setting. For dates of service on or after January 1, 2011, the professional component of diabetes screening tests is a covered FQHC service when provided by an FQHC. FQHCs should follow these billing instructions to ensure that proper payment is made for services and to allow the Common Working File (CWF) to perform age and frequency editing.

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

- **Technical Component** for Provider-Based FQHCs:
  - The base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **Technical Component** for Independent FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component** for Provider-Based FQHCs and Freestanding FQHCs:
  - Detailed Healthcare Common Procedure Coding System (HCPCS) coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment. An additional line with revenue code 052X should be submitted with the appropriate CPT code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive encounter rate, and coinsurance or copayment and deductible will not apply.
  - If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/CPT code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.

Reimbursement Information

General Information

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

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses diabetes screening test services under the Clinical Laboratory Fee Schedule.

National Correct Coding Initiative (NCCI) Edits

Refer to the currently applicable bundled carrier processed procedures at http://www.cms.gov/NationalCorrectCodInitEd on the CMS website.

Clinical Laboratory Fee Schedule

For more information about the Clinical Laboratory Fee Schedule, visit http://www.cms.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for diabetes screening tests depends on the type of facility providing the service. Table 4 lists the type of payment that facilities receive for diabetes screening tests.

Table 4 – Facility Payment Methodology for Diabetes Screening Tests*

Facility Type	Basis of Payment
Hospital	Clinical Laboratory Fee Schedule
Skilled Nursing Facility (SNF)**	Clinical Laboratory Fee Schedule
Critical Access Hospital (CAH)	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of Medicare Physician Fee Schedule (MPFS) non-facility rate for professional component(s) of services
Federally Qualified Health Center (FQHC) for dates of service on or after January 1, 2011	All-Inclusive Encounter Rate

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

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for diabetes screening tests for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Diabetes screening tests provided by other facility types must be reimbursed by the SNF.

Reasons for Claim Denial

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

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

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Diabetes Supplies

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

- Blood glucose self-testing equipment and associated accessories;
- Therapeutic shoes, including:
  - 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; and
- Insulin pumps and the insulin used in the pumps.

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

Blood Glucose Monitors and Associated Accessories

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

Coverage Information

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

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

Insulin-Dependent

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

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

Non-Insulin Dependent

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

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

NOTE: Medicare allows additional test strips and lancets if they are 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.

Medicare provides coverage of diabetes-related Durable Medical Equipment (DME) and supplies as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. If

the provider or supplier 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.

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) codes, listed in Table 5, must be used to report blood glucose self-testing equipment and supplies.

Table 5 – HCPCS Codes for Blood Glucose Self-Testing Equipment and Supplies

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

Therapeutic Shoes

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

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

Coverage Information

For Medicare to cover therapeutic shoes, the physician must certify that the beneficiary meets the following criteria:

- The beneficiary must have diabetes; and
- The beneficiary must have at least one of the following conditions:
  - Partial or complete amputation of a foot,
  - Foot ulcers,
  - Calluses that could lead to foot ulcers,
  - Nerve damage from diabetes and signs of calluses,
  - Poor circulation, or
  - A deformed foot.

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

For each beneficiary, 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), or
- No more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts.

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

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding Information

Procedure Codes and Descriptors

The following HCPCS codes, listed in Table 6, must be used to report therapeutic shoes.

Table 6 – HCPCS Codes for Therapeutic Shoes

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

Insulin Pumps

Insulin pumps that are worn outside the body and the insulin used with the pump may be covered for some beneficiaries who have diabetes and who meet certain conditions. Insulin pumps are available through a prescription.

Coverage Information

Beneficiaries must meet either Criterion A or Criterion B, listed in Table 7, to receive coverage for an external infusion pump for insulin and related drugs and supplies.

Table 7 – External Infusion Pump for Insulin and Related Drugs and Supplies Coverage Criteria*

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

***NOTE:** In addition to meeting Criterion A or Criterion B above, the beneficiary must be a beneficiary with diabetes who is insulinopenic per the updated fasting C-peptide testing requirement described below, or who is beta cell autoantibody positive.

The updated fasting C-peptide testing requirement is as follows:

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

Continued coverage of the insulin pump requires that the treating physician sees and evaluates the beneficiary at least every three months. A physician who manages multiple individuals with Continuous Subcutaneous Insulin Infusion (CSII) pumps and who works closely with a team including nurses, diabetes educators, and dietitians who are knowledgeable in the use of CSII must order the pump and manage follow-up care.

Medicare provides coverage of insulin pumps as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. When covered, Medicare will pay for the insulin pump, as well as the insulin used with the insulin pump. If the Medicare provider does not accept

assignment, the amount the beneficiary pays may be higher, and the beneficiary may be required to pay the full amount at the time of service. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding Information

Procedure Codes and Descriptors

The following HCPCS codes, listed in Table 8, must be used to report insulin pumps and supplies.

Table 8 – HCPCS Codes for Insulin Pumps and Supplies

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

Billing and Reimbursement Information for Diabetes Supplies

Billing Requirements

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

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

Reimbursement Information

General Information

Reimbursement of diabetes supplies is made by the four DME MACs based on the DME Fee Schedule. Medicare pays 80 percent of the approved Fee Schedule amount.

Medicare provides coverage of diabetes supplies as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. If the provider or supplier 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.

Reasons for Claim Denial

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

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

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

Medicare Contractor Contact Information

Refer to DME MAC, carrier/AB Medicare Administrative Contractor (carrier/AB MAC), and Fiscal Intermediary/AB MAC (FI/AB MAC) contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Diabetes Self-Management Training (DSMT) Services

Medicare provides coverage of Diabetes Self-Management Training (DSMT) services for beneficiaries who have been recently diagnosed with diabetes, were 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.

Medicare covers DSMT services when a certified provider who meets certain quality standards furnishes these services. DSMT services are intended to educate beneficiaries in the successful self-management of diabetes. A qualified DSMT program includes the following services:

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

DSMT services are aimed toward beneficiaries 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, other foot problems such as ulcers or deformities, or an amputation has been performed;
- Treated in an emergency room or have stayed overnight in a hospital because of diabetes; or
- Diagnosed with kidney disease related to diabetes.

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

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

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

- The DSMT program must be accredited as meeting quality standards by a Centers for Medicare & Medicaid Services (CMS)-approved national accreditation organization. Currently, CMS recognizes the American Diabetes Association (ADA), the American Association of Diabetes Educators (AADE), and the Indian Health Service (IHS) as approved national accreditation organizations. Programs without accreditation by a CMS-approved national accreditation organization are not covered.
- The DSMT program must provide services to eligible Medicare beneficiaries that are diagnosed with diabetes.
- The DSMT program must submit an accreditation certificate from the ADA, AADE, or IHS to the local Medicare Contractor's provider enrollment department.

For more information on DSMT enrollment, refer to the Internet-Only Manual, "Medicare Program Integrity Manual," Publication 100-08, Chapter 10 at http://www.cms.gov/manuals/downloads/pim83c10.pdf on the CMS website.

Coverage Information

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

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

Stand Alone Benefit

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

DSMT and Medical Nutrition Therapy (MNT) Separate Billable Services

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

Initial DSMT Training

The initial year for DSMT is the 12-month period following the required initial training certification.

Medicare will cover initial training that meets all of the following conditions:

- The initial training is furnished to a beneficiary who has not previously received initial or follow-up training billed under Healthcare Common Procedure Coding System (HCPCS) codes G0108 or G0109.
- The initial training is furnished within a continuous 12-month period.
- The initial training does not exceed a total of 10 hours (the 10 hours of training can be done in any combination of 30-minute increments and can be spread over the 12-month period or less).
- With the exception of one hour of individual training, the initial training is usually furnished in a group setting, which can contain individuals other than Medicare beneficiaries.
- The one hour of individual training may be used for any part of the training including insulin training.

Follow-Up DSMT Training

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

- The follow-up training consists of no more than two hours of individual or group training for a beneficiary each year.
- Group training consists of 2 to 20 individuals; not all need to be Medicare beneficiaries.
- Follow-up training is furnished in increments of no less than 30 minutes.
- The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

- Follow-up training for subsequent years is based on a 12-month calendar year after the completion of the full 10 hours of initial training. However, if the beneficiary exhausts 10 hours in the initial year then the beneficiary would be eligible for follow-up training in the next calendar year. If the beneficiary does not exhaust 10 hours of initial training, he/she has 12 continuous months to exhaust initial training before the 2 hours of follow-up training are available.

Examples

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

- Beneficiary receives first service: **April 2009**
- Beneficiary completes initial 10 hours DSMT training: **April 2010**
- Beneficiary is eligible for follow-up training: **May 2010** (13th month begins the subsequent year)
- Beneficiary completes follow-up training: **December 2010**
- Beneficiary is eligible for next year follow-up training: **January 2011**

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

- Beneficiary receives first service: **April 2009**
- Beneficiary completes initial 10 hours of DSMT training: **December 2009**
- Beneficiary is eligible for follow-up training: **January 2010**
- Beneficiary completes follow-up training: **July 2010**
- Beneficiary is eligible for next year follow-up training: **January 2011**

Individual DSMT Training

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

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

Telehealth

For dates of service on or after January 1, 2011, telehealth services include coverage for individual and group DSMT, with a minimum of one hour of in-person instruction to be furnished in the initial year training period, as described by HCPCS codes G0108 or G0109. In addition, certified registered dietitians and nutrition professionals may furnish and receive payment for a telehealth service.

All eligibility criteria, conditions of payment, payment, or billing methodology applicable to Medicare telehealth services apply to DSMT provided with telehealth. **Additionally, a minimum of one hour of in-person instruction in the self-administration of injectable drugs must be furnished to the beneficiary during the year following the initial DSMT service.** The injection training may be furnished through either individual or group DSMT services. To certify that the beneficiary has received or will receive one hour of in-person DSMT services for the purposes of injection training during the year following the initial

DSMT service, the distant site practitioner should report the -GT or -GQ modifier with HCPCS codes G0108 or G0109.

Originating sites must be located in either a non-Metropolitan Statistical Area (MSA) county or rural health professional shortage area and can only include a physician's or practitioner's office, hospital, Critical Access Hospital (CAH), Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). An interactive audio and video telecommunications system must be used that permits real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the beneficiary must be present and participating in the telehealth visit. The only exception to this interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In these circumstances, Medicare payment is permitted for telehealth services when asynchronous store-and-forward technology is used.

Coinsurance or Copayment and Deductible

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

NOTE: The Medicare Part B deductible does not apply to FQHCs.

Documentation

Documentation must show the original order from the physician and any special conditions noted by the physician. The plan of care must be reasonable and necessary and must be incorporated into the beneficiary's medical record.

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

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following HCPCS codes, listed in Table 9, must be used to report DSMT services.

Table 9 – HCPCS Codes for DSMT Services

HCPCS Code	Code Descriptor
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

Diagnosis Requirements

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

Billing Requirements

General Information

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

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

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

Also, the following conditions apply:

- A cover letter and National Provider Identifier (NPI) must be included with the accreditation certificate.
- The Medicare provider must have a provider and/or supplier number and the ability to bill Medicare for other services.
- Registered dietitians are eligible to bill on behalf of an entire DSMT program as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service.

  NOTE: For dates of service on or after March 20, 2009, there is an exception for rural areas. In a rural area, an individual who is qualified as a registered dietitian and is a certified diabetic educator who is currently certified by an organization approved by CMS may furnish training and is deemed to meet the multidisciplinary requirement.

DME suppliers that provide DSMT services are reimbursed through local carriers/AB Medicare Administrative Contractors (carriers/AB MACs).

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

Billing and Coding Requirements When Submitting Claims to Carriers/AB MACs

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS code and the corresponding International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Claims Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for DSMT services when submitted on the following TOBs and associated revenue codes, listed in Table 10.

Table 10 – Facility Types, TOBs, and Revenue Codes for DSMT Services*

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B	12X	0942
Hospital Outpatient	13X	0942
Skilled Nursing Facility (SNF)**	22X, 23X	0942
Indian Health Service (IHS) Provider Billing Hospital Outpatient Part B	13X	051X, 0942
IHS Provider Billing Hospital Inpatient Part B	12X	024X, 0942
IHS Critical Access Hospital (CAH) Billing Outpatient Part B	85X	051X, 0942
IHS CAH Billing Inpatient Part B	12X	024X, 0942
CAH***	12X, 85X	0942
Home Health Agency (HHA)	34X	0942
Federally Qualified Health Center (FQHC)	77X	052X
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12X, 13X	0942

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

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for DSMT for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. DSMT provided by other facility types must be reimbursed by the SNF.

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

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

DSMT Coding Tips

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

- For an hour session, a "2" must be placed in the "Units" column, representing two 30-minute increments.
- Billing an Evaluation and Management (E/M) code is not mandatory before billing the DSMT procedure codes. Do not use E/M codes in lieu of HCPCS codes G0108 and G0109.
- The nutrition portion of the DSMT program must be billed using HCPCS codes G0108 and G0109. Do not use the Medical Nutrition Therapy (MNT) CPT codes for the nutrition portion of a DSMT program.
- The DSMT and MNT 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 MNT benefit for diabetic patients is more effective if it is provided after completion of the initial DSMT benefit.
- Medicare pays for up to 10 hours of initial DSMT in a continuous 12-month period. Two hours of follow-up DSMT may be covered in subsequent years.

Certified Providers

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

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

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

Reimbursement Information

General Information

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

RHCs and FQHCs

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.

Medicare provides coverage for DSMT as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. Claims from physicians, qualified non-physician practitioners, or suppliers where assignment was not taken are subject to Medicare's limiting charge. However, the following non-physician practitioners must accept assignment for all of their services: physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, clinical social workers, and registered dietitians/nutritionists.

NOTE: The Medicare Part B deductible does not apply to FQHCs.

If the provider is billing for initial training, the beneficiary must not have previously received initial or follow-up training for which Medicare payment was made under this benefit.

Reimbursement of Claims by Carriers/AB MACs

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

Medicare Physician Fee Schedule (MPFS) Information

For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all DSMT services. However, the following non-physician practitioners must accept assignment for all of their services: physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, clinical social workers, and registered dietitians/nutritionists.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for DSMT depends on the type of facility providing the service. Table 11 lists the type of payment that facilities receive for DSMT.

Table 11 – Facility Payment Methodology for DSMT*

Facility Type	Basis of Payment
Hospital Subject to Outpatient Prospective Payment System (OPPS)	Medicare Physician Fee Schedule (MPFS)
Skilled Nursing Facility (SNF)**	MPFS non-facility rate
Indian Health Service (IHS) Provider Billing Hospital Outpatient Part B	Office of Management & Budget (OMB)-Approved Outpatient Per Visit All-Inclusive Rate (AIR)
IHS Provider Billing Inpatient Part B	All-Inclusive Inpatient Ancillary Per Diem Rate

Facility Type	Basis of Payment
IHS Critical Access Hospital (CAH) Billing Outpatient Part B	101% of the All-Inclusive Facility Specific Per Visit Rate
IHS CAH Billing Inpatient Part B	101% of the All-Inclusive Facility Specific Per Diem Rate
CAH***	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services
Home Health Agency (HHA) (can be billed only if the service is provided outside of the treatment plan)	MPFS non-facility rate
Federally Qualified Health Center (FQHC)****	All-Inclusive Encounter Rate (with other qualified services) Eligible to receive an additional encounter payment at the all-inclusive rate
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	94% of provider submitted charges or according to the terms of the Maryland Waiver

***NOTE:** ESRD facilities and RHCs are not included in this table. An ESRD facility is a reasonable site for this service; however, because it is required to provide dietitian and nutritional services as part of the care covered in the composite rate for DSMT, ESRD facilities are not allowed to bill for DSMT separately and do not receive separate reimbursement. Likewise, an RHC is a reasonable site for this service; however, DSMT must be provided in an RHC with other qualifying services and paid at the all-inclusive encounter rate. RHCs should include the charges on the claims for future inclusion in encounter rate calculations.

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for DSMT for beneficiaries that are in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. DSMT provided by other facility types must be reimbursed by the SNF.

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

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

******NOTE:** **For dates of service prior to January 1, 2011,** payment for DSMT provided in an FQHC as a one-on-one, face-to-face encounter may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed on TOB 77X, with HCPCS code G0108 and revenue code 052X. (For FQHCs, codes representing group sessions do not constitute a separate billable visit. Therefore, although services billed under G0109 can be provided, they cannot be separately paid outside of the single daily encounter rate.)

For dates of service on or after January 1, 2011, the professional component of DSMT is a covered FQHC service when provided by an FQHC. FQHCs receive the all-inclusive encounter rate for DSMT services billed under HCPCS codes G0108 or G0109 on TOB 77X with revenue code 052X.

Additional Reimbursement Information for RHCs and FQHCs

Medicare does not make separate payment for this service to RHCs. The service is covered and included in the all-inclusive encounter rate. RHCs are permitted to become certified providers of DSMT services. RHCs should include the charges on the claims for future inclusion in encounter rate calculations.

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

NOTE: The provision of these services by registered dietitians or nutrition professionals might be considered "incident to" services in the RHC setting, provided all applicable conditions are met. However, they do not constitute an RHC visit.

FQHCs are eligible for a separate payment under Part B for one-on-one, face-to-face DSMT encounter services provided they meet all program requirements. For more information, refer to the Internet-Only Manual, "Medicare Claims Processing Manual," Publication 100-04, Chapter 18 at http://www.cms.gov/manuals/downloads/clm104c18.pdf on the CMS website. Medicare makes payment to FQHCs at the all-inclusive encounter rate. Payment for DSMT provided in an FQHC may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed on TOB 77X and revenue code 052X.

NOTE: For FQHCs, codes representing group sessions do not constitute a separate billable visit. Therefore, although services billed under G0109 can be provided, they cannot be separately paid outside of the single daily encounter rate.

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

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of DSMT services.

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information available at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Medical Nutrition Therapy (MNT)

Medicare provides coverage of Medical Nutrition Therapy (MNT) for beneficiaries diagnosed with diabetes or renal disease (except for those receiving dialysis). MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

The MNT benefit allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement.

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

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

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

Diabetes Mellitus

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

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

Renal Disease

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

Coverage Information

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

- The beneficiary has diabetes or renal disease.
- The treating physician must provide a referral and indicate a diagnosis of diabetes or renal disease. A treating physician means the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease (non-physician practitioners cannot make referrals for this service).
- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician.
- MNT services may be provided either on an individual or group basis without restrictions.

Stand Alone Benefit

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

- MNT services must be provided by a registered dietitian, or a nutrition professional who meets the provider qualification requirements, or a "grandfathered" dietitian or nutritionist who was licensed as of December 21, 2000. (See the Professional Standards for Dietitians and Nutrition Professionals section later in this chapter.)
- For a beneficiary with a diagnosis of diabetes, DSMT and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary.
- For the beneficiary with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the beneficiary may receive MNT services based on a change in medical condition, diagnosis, or treatment.

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

MNT and DSMT Separate Billable Services

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

Medicare provides coverage of MNT as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

Limitations on Coverage

The following limitations apply:

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

Referrals for MNT Services

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

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

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

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

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

Telehealth

Telehealth services include coverage for individual MNT as described by Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes G0207, 97802, and 97803 (as well as 97804 for dates of service on or after January 1, 2011). In addition, certified registered dietitians and nutrition professionals may furnish and receive payment for a telehealth service.

All eligibility criteria, conditions of payment, payment, or billing methodology applicable to Medicare telehealth services apply to MNT provided with telehealth. Originating sites must be located in either a non-Metropolitan Statistical Area (MSA) county or rural health professional shortage area and can only include a physician's or practitioner's office, hospital, Critical Access Hospital (CAH), Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). An interactive audio and video telecommunications system must be used that permits real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the beneficiary must be present and participating in the telehealth visit. The only exception to this interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In these circumstances, Medicare payment is permitted for telehealth services when asynchronous store-and-forward technology is used.

Professional Standards for Dietitians and Nutrition Professionals

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means an individual who meets one of the following sets of criteria.

An individual is a "registered dietitian or nutrition professional" if, on or after December 22, 2000, the individual:

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

However, even an individual who does not meet the criteria listed above may be a "registered dietitian or nutrition professional:"

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

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Enrollment of Dietitians and Nutrition Professionals

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

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

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following HCPCS/CPT codes, listed in Tables 12 and 13, must be used to report MNT.

Table 12 – HCPCS/CPT Codes for MNT

HCPCS/CPT Code	Code Descriptor
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes **NOTE:** This CPT code must only be used for the initial visit.
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

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Table 13 – Instructions for Use of the MNT Codes

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

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

NOTE: Telehealth modifiers -GT (via interactive audio and video telecommunications system) and -GQ (via synchronous telecommunications system) are valid when billed with HCPCS/CPT codes G0270, 97802, and 97803.

Diagnosis Requirements

MNT services are available for beneficiaries with diabetes or renal disease. The treating physician must make a referral and indicate an International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code of diabetes or renal disease. For further guidance, contact the local Medicare Contractor.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB MACs

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT code and the corresponding ICD-9-CM diagnosis code in the X12 837 Professional electronic claim format.

The referring physician's provider number must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. Non-physician practitioners cannot make referrals for this service.

Registered dietitians and nutrition professionals can be part of a group practice. In that case, the provider identification number of the registered dietitian or nutrition professional who performed the service must be entered on the claim form.

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NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Billing and Coding Requirements When Submitting Claims to FIs/AB MACs

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837 Institutional electronic claim format.

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

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for MNT services when submitted on the following TOBs and associated revenue codes, listed in Table 14.

Table 14 – Facility Types, TOBs, and Revenue Codes for MNT*

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	0942
Skilled Nursing Facility Outpatient (SNF)	23X	0942
Home Health Agency (HHA) (not under an HHA plan of care)	34X	0942
Critical Access Hospital (CAH)	85X	0942
Federally Qualified Health Center (FQHC) for dates of service on or after January 1, 2011**	77X	052X

***NOTE:** Separate payment to RHCs (TOB 71X) is precluded as these services are not within the scope of the Medicare-covered RHC benefits.

****NOTE: For dates of service prior to January 1, 2011,** FQHCs may qualify for a separate visit for payment for MNT services in addition to any other qualifying visit on the same date of service, as long as the services provided were individual services and billed with the appropriate site of service revenue code in the 052X series on a 77X TOB. Group services do not meet the criteria for a separate qualifying encounter.

For dates of service on or after January 1, 2011, the professional component of MNT is a covered FQHC service when provided by an FQHC. FQHCs receive the all-inclusive encounter rate for MNT services billed under the appropriate HCPCS/CPT code on a 77X TOB with revenue code 052X.

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

Reimbursement Information

General Information

Medicare provides coverage of MNT as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

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

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses MNT under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all MNT services.

Medicare Physician Fee Schedule (MPFS) Information

For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the MNT depends on the type of facility providing the service. Table 15 lists the type of payment that facilities receive for MNT.

Table 15 – Facility Payment Methodology for MNT*

Facility Type	Basis of Payment
Hospital Outpatient	Medicare Physician Fee Schedule (MPFS)
Skilled Nursing Facility (SNF) Outpatient	MPFS
Home Health Agency (HHA) (not under an HHA plan of care)	MPFS
Critical Access Hospital (CAH)**	Reasonable cost
Federally Qualified Health Center (FQHC) for dates of service on or after January 1, 2011	All-Inclusive Encounter Rate

***NOTE:** For MNT paid under the MPFS, payment is the lesser of the actual charge or 85 percent of the MPFS.

****NOTE:** For CAHs, if the distant site is a CAH that has elected Method II and the physician or non-physician practitioner has reassigned his/her benefits to this CAH, the CAH should bill its regular FI/AB MAC for the professional telehealth services provided using revenue codes 096X, 097X, or 098X. In addition, all requirements for billing distant site telehealth services apply.

Additional Reimbursement Information for RHCs and FQHCs

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

While Medicare does not make separate payment for this service to RHCs, similar services may be covered when furnished by, or "incident to," an RHC professional. Payment is included in the all-inclusive encounter rate when covered. RHCs should include the charges on the claims for future inclusion in encounter rate calculations.

For dates of service prior to January 1, 2011, FQHCs that are certified providers of MNT services can receive per-visit payments for covered services rendered by registered dietitians or nutrition professionals. These services are included under the FQHC benefit as billable visits. **For dates of service on or after January 1, 2011, the professional component of MNT is a covered FQHC service when provided by an FQHC. FQHCs receive the all-inclusive encounter rate for MNT services.**

Reasons for Claim Denial

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

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Other Diabetes Services

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

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

*Retinal eye exams for diabetic retinopathy may be covered as a medically necessary diagnostic exam furnished to beneficiaries diagnosed with diabetes.

Details regarding Medicare's coverage of glaucoma screening services and influenza and pneumococcal vaccinations are described in this Guide. For specific information regarding other diabetes services, refer to relevant Centers for Medicare & Medicaid Services (CMS) documentation.

Diabetes Supplies and Services Not Covered by Medicare

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

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

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

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

Diabetes-Related Services

Resources

American Association of Diabetes Educators
http://www.diabeteseducator.org/ProfessionalResources/accred

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

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

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

Centers for Disease Control and Prevention (CDC) Diabetes Data and Trends
http://apps.nccd.cdc.gov/DDTSTRS

CDC Diabetes Public Health Resource
http://www.cdc.gov/diabetes/consumer

IHS Division of Diabetes Treatment and Prevention
http://www.ihs.gov/MedicalPrograms/Diabetes

Medicare Learning Network® (MLN) Preventive Services Educational Products Website
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

National Diabetes Education Program
http://www.ndep.nih.gov

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

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

Diabetes Screening

CMS Diabetes Screening Web Page
https://www.cms.gov/DiabetesScreening

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

USPSTF Recommendations
This website provides the USPSTF written recommendations for type 2 diabetes mellitus in adults.
http://www.uspreventiveservicestaskforce.org/uspstf/uspsdiab.htm

DSMT

CMS Diabetes Self-Management Web Page
https://www.cms.gov/DiabetesSelfManagement

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

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

MLN Matters® Article 6510, "Diabetes Self-Management Training (DSMT) Certified Diabetic Educator"
http://www.cms.gov/MLNMattersArticles/Downloads/MM6510.pdf

MNT

American Dietetic Association Information on Medical Nutrition Therapy
http://www.eatright.org/HealthProfessionals/content.aspx?id=6877&terms=mnt

CMS Medical Nutrition Therapy Web Page
http://www.cms.gov/MedicalNutritionTherapy

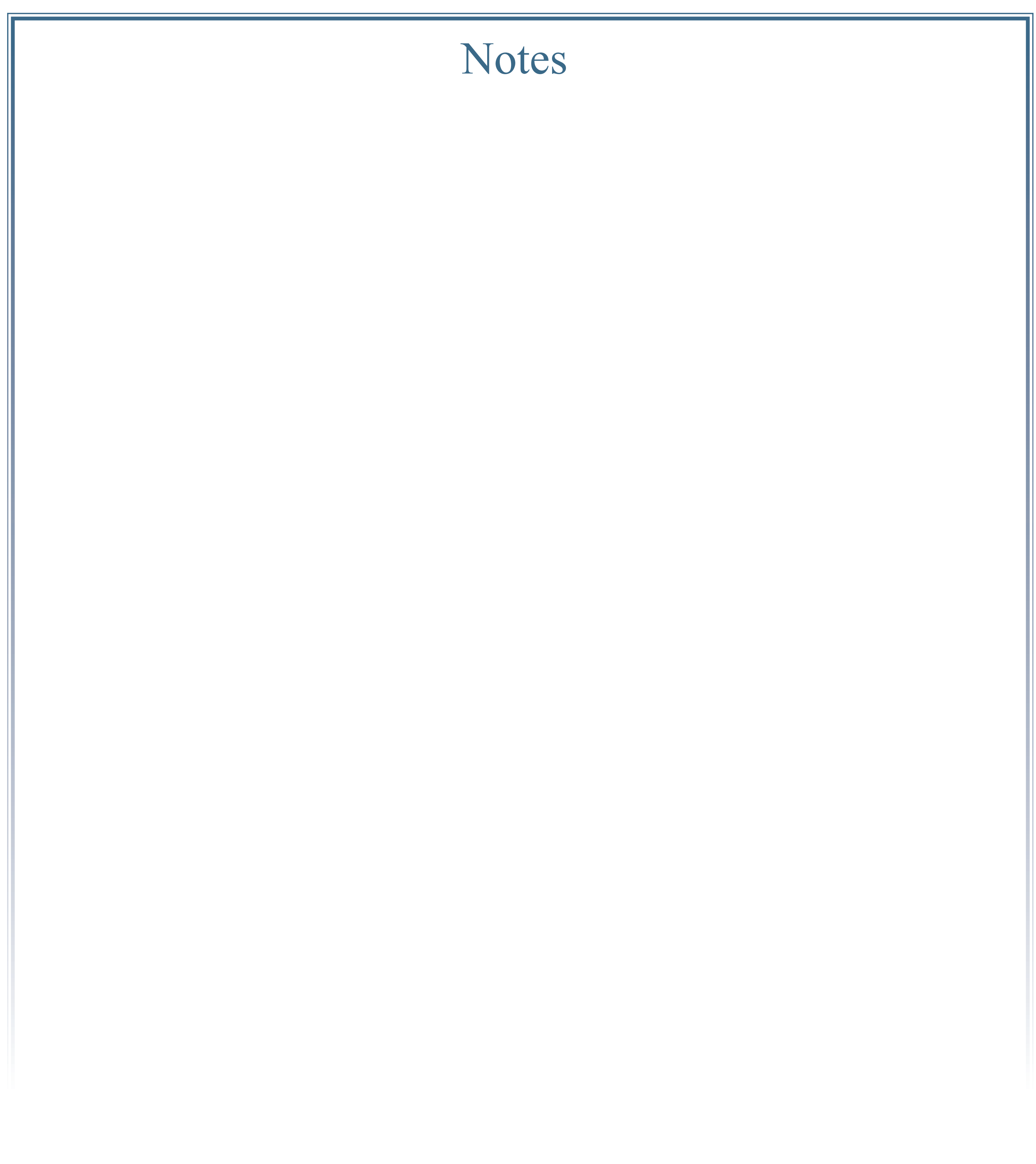
"Medicare Claims Processing Manual" – Publication 100-04, Chapter 4, Section 300
http://www.cms.gov/manuals/downloads/clm104c04.pdf

National Kidney and Urologic Diseases Information Clearinghouse
http://kidney.niddk.nih.gov

National Kidney Disease Education Program
http://nkdep.nih.gov

More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes


Notes

Chapter 7
Glaucoma Screening

Overview

Glaucoma represents a family of diseases commonly associated with optic nerve damage and visual field changes (a narrowing of the eyes' usual scope of vision). Of the various forms of glaucoma (such as congenital, angle-closure, and secondary), open-angle glaucoma is the most common. Glaucoma occurs when increased fluid pressure in the eye presses against the optic nerve, causing damage. The damage to optic nerve fibers can cause blind spots to develop. These blind spots usually go undetected until the optic nerve is significantly damaged. If the entire optic nerve is destroyed, blindness results. Since glaucoma progresses with few or no warning signs or symptoms and vision loss from glaucoma is irreversible, annual screening of people at high risk for the disease is vitally important. Studies show that early detection and treatment of glaucoma, before it causes major vision loss, is the best way to control the disease.

Medicare coverage of glaucoma screenings began for dates of service on or after January 1, 2002.

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

The coinsurance or copayment and deductible for glaucoma screening are not waived. The USPSTF has not given glaucoma screening a grade of A or B, so the Affordable Care Act will not waive the coinsurance or copayment or deductible.

The glaucoma screening covered by Medicare includes the following:

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

Increased IOP is common with glaucoma. In the past, health care professionals followed the treatment protocol associated with increased IOP measurement for an indication of glaucoma; an IOP measurement using non-contact tonometry (more commonly known as the "air puff test") alone was commonly used to diagnose glaucoma. Now, health care professionals know that glaucoma can be present with or without increased IOP, which makes the examination of the eye and optic nerve (along with the IOP measurement) a critical part of the glaucoma screening.

Risk Factors

While anyone can develop glaucoma, certain groups of people are at higher risk for the disease. Risk factors that may increase an individual's chances of developing glaucoma include the following:

- Age,
- Race,
- Family history, and
- Medical history.

Coverage Information

Medicare provides coverage of an annual glaucoma screening (i.e., at least 11 months after the last covered glaucoma screening was performed) for beneficiaries in at least one of the following high risk categories:

- Individuals with diabetes mellitus,
- Individuals with a family history of glaucoma,
- African-Americans aged 50 and older, and
- Hispanic-Americans aged 65 and older.

Stand Alone Benefit

The glaucoma screening benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

Because of the prevalence of glaucoma in these groups, health care professionals should encourage all eligible Medicare beneficiaries who are members of one of the high risk groups to get regular glaucoma screenings.

Medicare pays for glaucoma screenings in an office setting furnished by or under the direct supervision of an optometrist or ophthalmologist legally authorized to perform services under state law.

NOTE: Medicare does not provide coverage for routine eye refractions.

Calculating Frequency

When calculating frequency to determine the 11-month period, the count starts beginning with the month after the month in which a previous test was performed.

EXAMPLE: The beneficiary received a glaucoma screening in January 2010. The count starts beginning February 2010. The beneficiary is eligible to receive another glaucoma screening in January 2011 (the month after 11 months have passed).

Coinsurance or Copayment and Deductible

Coverage of the glaucoma screening service is provided as a Medicare Part B benefit. Both coinsurance or copayment and the Medicare Part B deductible apply.

NOTE: The Medicare Part B deductible does not apply to Federally Qualified Health Center (FQHC) services.

Documentation

Medical record documentation must show that the beneficiary is a member of one of the high risk groups. The documentation must also show that the appropriate screening was performed (i.e., either a dilated eye examination with an IOP measurement and a direct ophthalmoscopic examination **or** a slit-lamp biomicroscopic examination).

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) codes, listed in Table 1, must be used to report glaucoma screening.

Table 1 – HCPCS Codes for Glaucoma Screening

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

Diagnosis Requirements

The beneficiary must be a member of one of the high risk groups to receive a covered glaucoma screening. Medicare providers must report the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening ("V") diagnosis code, listed in Table 2, for glaucoma screening. For further guidance, contact your Medicare Contractor.

Table 2 – Diagnosis Code for Glaucoma Screening

ICD-9-CM Diagnosis Code	Code Descriptor
V80.1	Special screening for neurological, eye, and ear disease, glaucoma

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS code (G0117 or G0118) and the corresponding ICD-9-CM diagnosis code (V80.1) in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code (G0117 or G0118), the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code (V80.1) in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for glaucoma screening when submitted on the following TOBs and associated revenue codes, listed in Table 3.

Table 3 – Facility Types, TOBs, and Revenue Codes for Glaucoma Screening

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	Hospital outpatient departments are not required to report revenue code 0770; claims must be billed using any valid/appropriate revenue code.
Skilled Nursing Facility (SNF) Inpatient Part B*	22X	0770
SNF Outpatient	23X	0770
Rural Health Clinic (RHC)	71X	052X See Additional Billing Instructions for RHCs and FQHCs
Federally Qualified Health Center (FQHC)	77X	052X See Additional Billing Instructions for RHCs and FQHCs
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0770
Critical Access Hospital (CAH)**	85X	0770

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for glaucoma screening for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Glaucoma screenings provided by other facility types must be reimbursed by the SNF.

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

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

Additional Billing Instructions for RHCs and FQHCs

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

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

> **FQHC TOB**
>
> For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

- **Technical Component** for Provider-Based RHCs and FQHCs:
  - The base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **Technical Component** for Independent RHCs and FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component** for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a physician or qualified non-physician practitioner furnishes a glaucoma screening within an RHC/FQHC, the screening is considered an RHC/FQHC service. The provider of a glaucoma screening must bill the FI/AB MAC under TOB 71X or 77X, respectively. The professional portion of the service is billed to the FI/AB MAC using revenue code 052X. Beginning with dates of service on or after January 1, 2011, FQHCs must report all pertinent services provided and list the appropriate HCPCS code for each line item along with the revenue code(s) for each FQHC visit.

Reimbursement Information

General Information

Medicare provides coverage of glaucoma screening as a Medicare Part B benefit. Medicare Part B pays 80 percent of the Medicare-approved amount for the glaucoma screening (coinsurance or copayment and the Medicare Part B deductible apply).

NOTE: The Medicare Part B deductible does not apply to FQHC services.

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses the glaucoma screening under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all glaucoma screening services.

> **Medicare Physician Fee Schedule (MPFS) Information**
>
> For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the glaucoma screening depends on the type of facility providing the service. **For providers billing Outpatient Prospective Payment System (OPPS) claims, HCPCS code G0118 is bundled with HCPCS code G0117 when both are billed on the same day.** These codes are not bundled for other providers billing FIs/AB MACs. Table 4 lists the type of payment that facilities receive for glaucoma screening.

Outpatient Prospective Payment System (OPPS) Information

For more information about OPPS, visit http://www.cms.gov/HospitalOutpatientPPS on the CMS website.

Table 4 – Facility Payment Methodology for Glaucoma Screening

Facility Type	Basis of Payment
Hospital Outpatient	Outpatient Prospective Payment System (OPPS)
Skilled Nursing Facility (SNF) Inpatient Part B*	Medicare Physician Fee Schedule (MPFS)
SNF Outpatient	MPFS
Rural Health Clinic (RHC)**	All-Inclusive Encounter Rate
Federally Qualified Health Center (FQHC)	All-Inclusive Encounter Rate
Comprehensive Outpatient Rehabilitation Facility (CORF)	MPFS
Critical Access Hospital (CAH)	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for glaucoma screening for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Glaucoma screenings provided by other facility types must be reimbursed by the SNF.

****NOTE:** RHCs should include the charges on the claims for future inclusion in encounter rate calculations.

Reasons for Claim Denial

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

- The beneficiary received a covered glaucoma screening during the past year.
- The beneficiary is not a member of one of the high risk groups.

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Glaucoma Screening

Resources

CMS Glaucoma Screening Web Page
http://www.cms.gov/GlaucomaScreening

The Glaucoma Foundation Website
http://www.glaucomafoundation.org

"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 280.1
http://www.cms.gov/manuals/Downloads/bp102c15.pdf

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 70
http://www.cms.gov/manuals/downloads/clm104c18.pdf

Medicare Learning Network® (MLN) "Glaucoma Screening" Brochure (ICN 006436)
http://www.cms.gov/MLNProducts/downloads/Glaucoma.pdf

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

National Eye Institute
Website provides links to Medicare benefits resources that can be ordered by health care professionals for distribution at health fairs, clinics, meal sites, senior centers, and other community locations.
http://www.nei.nih.gov/medicare

Prevent Blindness America Website
http://www.preventblindness.org

USPSTF Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations on screening for glaucoma.
http://www.uspreventiveservicestaskforce.org/uspstf/uspsglau.htm

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More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes

Notes

Chapter 8
Screening Mammography

Overview

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

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

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

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible for screening mammographies are waived under the Affordable Care Act, based on the USPSTF 2002 recommendation on breast cancer screening.

Screening Mammography

A screening mammogram is a radiologic procedure, an X-ray of the breast, used for the early detection of breast cancer in women who have no signs or symptoms of the disease and includes a physician's interpretation of the results. Unlike a diagnostic mammogram, the presence of signs, symptoms, or a history of breast disease are not required for Medicare to cover the exam. The exam usually involves two X-rays of each breast. Screening mammograms can allow detection of tumors that cannot be felt. Screening mammograms can also find microcalcifications (tiny deposits of calcium in the breast) that sometimes indicate the presence of breast cancer.

Diagnostic Mammography

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

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

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

Risk Factors

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

- She is older;
- She has a personal history of breast cancer;
- She has a family history of breast cancer;
- She has dense breast tissue;
- She has been diagnosed with certain benign breast conditions;
- She is white;
- She started menstruation before age 12 or menopause after age 55;
- She has a personal history of chest radiation therapy;
- She or her mother were given the drug diethylstilbestrol (DES) during pregnancy;
- She had her first baby after age 30;
- She has never had a baby;
- She consumes excessive amounts of alcohol; or
- She is overweight or obese.

Coverage Information

Medicare provides coverage of an annual screening mammogram (i.e., at least 11 months after the last covered screening mammogram was performed) for all female beneficiaries aged 40 and older. Medicare also provides coverage of one baseline screening mammogram for female beneficiaries 35 through 39 years of age.

A physician's prescription or referral is not necessary for a screening mammogram to be covered by Medicare. Medicare determines whether to make payment for this procedure based on a woman's age and statutory frequency parameters.

Coverage for Screening Mammography Services

- Aged 35 and younger: No payment allowed
- Aged 35 through 39 years: Baseline (only one screening allowed for women in this age group)
- Aged 40 and older: Annual (at least 11 months after the last covered breast cancer screening mammogram)

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

NOTE: Mammography services must be provided in a Food and Drug Administration (FDA)-certified radiological facility under the Mammography Quality Standards Act (MQSA). A qualified physician who is directly associated with the facility where the mammogram was taken must interpret the results.

Need for Additional Films

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

> **Who Are Physicians and Qualified Non-Physician Practitioners?**
>
> **Physician**
>
> A physician is defined as a doctor of medicine or osteopathy.
>
> **Qualified Non-Physician Practitioner**
>
> For the purpose of the screening mammography, a qualified non-physician practitioner is a physician assistant, nurse practitioner, clinical nurse specialist, or nurse midwife.

Calculating Frequency

When calculating frequency to determine the 11-month period, the count starts beginning with the month after the month in which a previous test was performed.

EXAMPLE: The beneficiary received a screening mammography in January 2010. The count starts beginning February 2010. The beneficiary is eligible to receive another screening mammography in January 2011 (the month after 11 months have passed).

Coinsurance or Copayment and Deductible

Medicare provides coverage for screening mammography as a Medicare Part B benefit. The coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

> **Stand Alone Benefit**
>
> The screening mammography benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

Medicare also covers digital technologies for screening mammograms. The coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

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

NOTE: The Medicare Part B deductible does not apply to Federally Qualified Health Center (FQHC) services.

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, listed in Table 1, must be used to report screening mammography. Table 2 lists HCPCS/CPT codes that must be used to report diagnostic mammography.

Table 1 – HCPCS/CPT Codes for Screening Mammography

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

Table 2 – HCPCS/CPT Codes for Diagnostic Mammography

HCPCS/CPT Code	Code Descriptor
77051	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure) (Use 77051 in conjunction with 77055, 77056)
77055	Mammography; unilateral (Use 77055 in conjunction with 77051 for computer-aided detection applied to a diagnostic mammogram)
77056	Mammogram; bilateral (Use 77056 in conjunction with 77051 for computer-aided detection applied to a diagnostic mammogram)
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views

Diagnosis Requirements

Medicare payment for screening mammographies is not based on high risk indicators. However, to ensure proper coding, Medicare providers must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening (“V”) diagnosis codes, listed in Table 3, for screening mammography.

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Table 3 – Diagnosis Codes for Screening Mammography

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

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

Billing Requirements

General Information

Mammography services may be billed by the following three categories:

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

Global billing is not permitted for services furnished in an outpatient facility. Critical Access Hospitals (CAHs) may not use global HCPCS/CPT codes as the TC and PC components are paid under different methodologies. See Table 5 below.

When submitting a claim for a screening mammogram and a diagnostic mammogram for the same beneficiary on the same day, the Medicare provider must attach modifier -GG to the diagnostic mammogram (CPT codes 77055 and 77056 or HCPCS codes G0204 or G0206). Medicare requires that modifier -GG be appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Medicare will reimburse for the screening mammogram and 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.

Computer-Aided Detection (CAD) payment is built into the payment of the digital mammography. 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.

Payment for the Computer-Aided Detection (CAD) mammography (CPT codes 77051 and 77052) cannot be made if billed alone. If the beneficiary receives CAD mammography as part of a Medicare screening or diagnostic mammography, the CAD codes must be billed in conjunction with primary service codes (Tables 1 and 2).

All facilities providing screening and diagnostic mammography must have a certificate issued by the FDA in order to be reimbursed by Medicare. The appropriate FDA certification number must be included on claims submitted to the carrier/AB Medicare Administrative Contractor (carrier/AB MAC) for the film

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and/or digital mammography. Note that this number should not be included on claims submitted to the Fiscal Intermediary/AB Medicare Administrative Contractor (FI/AB MAC).

Billing and Coding Requirements When Submitting Claims to Carriers/AB MACs

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT code and the corresponding ICD-9-CM diagnosis code on the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

NOTE: When a provider bills for a screening mammography or diagnostic service that has been purchased from a provider located in another Medicare Contractor's jurisdiction, the billing provider must report its own National Provider Identifier (NPI) on a paper or electronically-submitted Medicare claim (as the billing provider), report its own NPI as the performing provider, and annotate the claim with the name, address, and ZIP code of the performing provider.

Billing and Coding Requirements When Submitting Claims to FIs/AB MACs

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code on the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

NOTE: Institutional providers submitting claims for self-referred mammography services are to duplicate the institution's own NPI (not a surrogate Unique Physician Identification Number [UPIN]) in the attending physician NPI field on claims. Suppliers submitting claims for self-referred mammography services are to duplicate the supplier's own NPI in the attending/referring physician NPI field on their claims.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for mammography when submitted on the following TOBs listed in Table 4.

Table 4 – Facility Types, TOBs, and Revenue Codes for Mammography

Facility Type	Mammography Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	For screening mammography	12X	0403
Hospital Inpatient Part B including CAH	For diagnostic mammography	12X	0401
Hospital Outpatient	For screening mammography	13X	0403
Hospital Outpatient	For diagnostic mammography	13X	0401
Skilled Nursing Facility (SNF) Inpatient Part B*	For screening mammography	22X	0403
SNF Inpatient Part B*	For diagnostic mammography	22X	0401
SNF Outpatient	For screening mammography	23X	0403
SNF Outpatient	For diagnostic mammography	23X	0401
Rural Health Clinic (RHC)	For screening mammography	71X	052X See Additional Billing Instructions for RHCs and FQHCs
RHC	For diagnostic mammography	71X	052X See Additional Billing Instructions for RHCs and FQHCs
Federally Qualified Health Center (FQHC)	For screening mammography	77X	052X See Additional Billing Instructions for RHCs and FQHCs
FQHC	For diagnostic mammography	77X	052X See Additional Billing Instructions for RHCs and FQHCs
CAH Outpatient**	For screening mammography	85X	0403, 096X, 097X, 098X
CAH Outpatient**	For diagnostic mammography	85X	0401, 096X, 097X, 098X

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for mammography for beneficiaries in a skilled Part A stay; however, the SNF must submit these

services on a 22X TOB. However, Medicare does not pay SNFs for HCPCS code G0236 for CAD with diagnostic mammography. See Reimbursement of Claims by FIs/AB MACs. Mammography provided by other facility types must be reimbursed by the SNF.

****NOTE:** Method I – All technical components are paid using standard institutional billing practices. See Table 5 below for further explanation of payment and revenue codes.

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, or 098X. **(This pertains to physicians/non-physician practitioners who have reassigned their billing rights to the Method II CAH.)** See Table 5 below for further explanation of payment and revenue codes.

Additional Billing Instructions for RHCs and FQHCs

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

There are specific billing and coding requirements for the TC when a screening mammography is furnished in an RHC or an FQHC.

> **FQHC TOB**
>
> For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

- **TC** for Provider-Based RHCs and FQHCs:
  - The base provider can bill the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **TC** for Independent RHCs and FQHCs:
  - The practitioner can bill the TC of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **PC for Dates of Service Prior to January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a physician or qualified non-physician practitioner furnishes a mammography within an RHC/FQHC, the screening or diagnostic mammography is considered an RHC/FQHC service. The provider of a mammography must bill the FI/AB MAC under TOB 71X or 77X, respectively. The PC of the service is billed to the FI/AB MAC using revenue code 052X.
- **PC for Dates of Service on or After January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - For screening mammographies, detailed HCPCS coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The RHC/FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment (and deductible for RHCs). An additional line with revenue code 052X should be submitted with the appropriate HCPCS code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive encounter rate, and coinsurance or copayment and deductible will not apply. If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/CPT code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.
  - For diagnostic mammographies, the same process is followed as described above for dates of service prior to January 1, 2011.

- Although most preventive services have HCPCS/CPT codes that allow separate billing of PCs and TCs, mammography does not. However, RHCs/FQHCs still may provide the PC of these services since they are in the scope of the RHC/FQHC benefit. Such encounters are billed on line items using revenue code 052X.

Reimbursement Information

General Information

Medicare provides coverage of screening mammography as a Medicare Part B benefit. The coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

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

NOTE: The Medicare Part B deductible does not apply to FQHC services.

Reimbursement for CAD mammography CPT codes 77051 and 77052 cannot be made if billed alone. They must be billed in conjunction with the primary service codes (Tables 1 and 2).

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare bases reimbursement for mammography on the lower of the actual charge or the Medicare Physician Fee Schedule (MPFS) amount for the service billed.

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

> **Medicare Physician Fee Schedule (MPFS) Information**
>
> For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for mammography is based on the lower of the actual charge or the MPFS amount for the service billed, with the exception of CAHs, RHCs, and FQHCs. Table 5 lists the type of payment that these facilities receive for mammography.

NOTE: A SNF can provide both screening and diagnostic mammography services; however, Medicare does not pay SNFs for HCPCS code G0236 for CAD with diagnostic mammography.

> **National Correct Coding Initiative (NCCI) Edits**
>
> Refer to the currently applicable bundled carrier processed procedures at http://www.cms.gov/NationalCorrectCodInitEd on the CMS website.

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Table 5 – Facility Payment Methodology for Mammography Furnished by Facilities

Facility Type	Basis of Payment
Critical Access Hospital (CAH)*	Method I: For breast cancer screening mammography, Medicare Physician Fee Schedule (MPFS) non-facility rate for the Technical Component (TC) under revenue code 0403. For diagnostic mammography, 101% of reasonable cost for TC under revenue code 0401. Method II: For breast cancer screening mammography, MPFS non-facility rate for the TC under revenue code 0403 and 115% of the MPFS facility rate for the Professional Component (PC) under revenue codes 096X, 097X, or 098X. For diagnostic mammography, 101% of reasonable cost for TC under revenue code 0401 and 115% of MPFS facility rate for the PC under revenue codes 096X, 097X, or 098X.
Rural Health Clinic (RHC)	All-Inclusive Encounter Rate
Federally Qualified Health Center (FQHC)	All-Inclusive Encounter Rate

***NOTE:** CAHs must not use modifiers -TC or -26. The revenue code selected by the provider determines the TC versus the PC.

Reasons for Claim Denial

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

- The beneficiary is not at least aged 35 or older.
- The beneficiary received a covered screening mammogram during the past year.
- The beneficiary received a screening mammogram from a non-FDA-certified mammography provider.

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Screening Mammography

Resources

Breast Cancer Facts & Figures 2009-2010
A comprehensive resource including many breast cancer statistics produced by the American Cancer Society.
http://www.cancer.org/Research/CancerFactsFigures/BreastCancerFactsFigures

Breast Cancer Prevention (PDQ®)
A guide to breast cancer prevention produced by the National Cancer Institute.
http://www.cancer.gov/cancertopics/pdq/prevention/breast/Patient/page3

CMS Mammography Web Page
http://www.cms.gov/Mammography

FDA List of Mammography Facilities
http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm

FDA MQSA and Program
http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram

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

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

Medicare Learning Network® (MLN) "Cancer Screenings" Brochure (ICN 006434)
http://www.cms.gov/MLNProducts/downloads/Cancer_Screening.pdf

"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 220.4
http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

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

National Cancer Institute Screening and Testing to Detect Cancer: Breast Cancer
http://www.cancer.gov/cancertopics/screening/breast

USPSTF Recommendations
This website provides the USPSTF written recommendations on breast cancer screening.
http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm

What Are the Key Statistics About Breast Cancer?
This website provides a breast cancer fact sheet produced by the American Cancer Society.
http://www.cancer.org/Cancer/BreastCancer/DetailedGuide/breast-cancer-key-statistics

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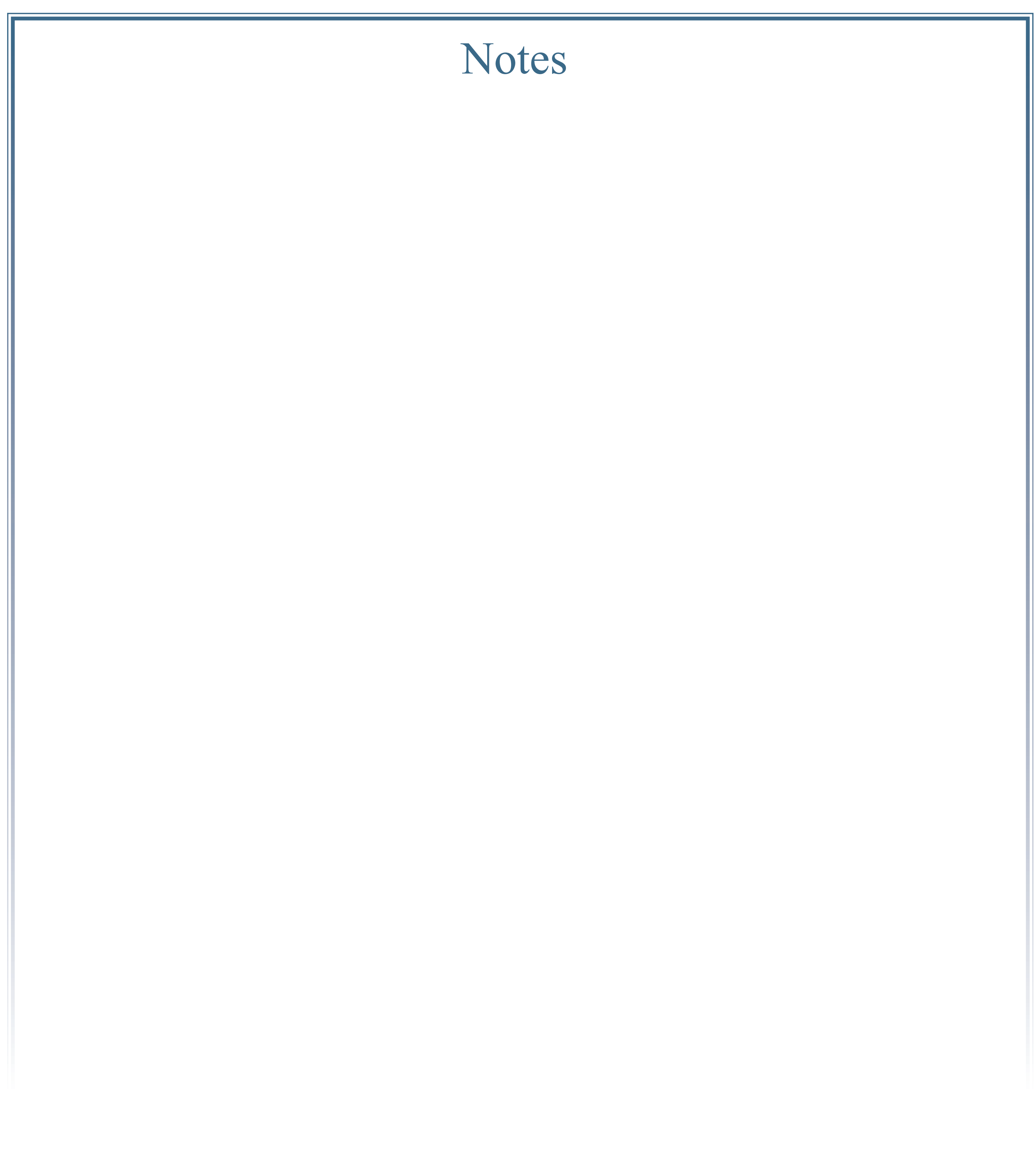
More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.



Notes

Chapter 9
Screening Pap Tests

Overview

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

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

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible for the screening Pap test are waived under the Affordable Care Act.

Risk Factors

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

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

Additional high risk factors for cervical and vaginal cancer include:

- Smoking, and
- Using birth control pills for an extended period of time (five or more years).

Coverage Information

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

Stand Alone Benefit

The screening Pap test benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

Covered Once Every 12 Months

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

- Evidence (medical history or other findings) shows that the woman is in one of the high risk categories for developing cervical or vaginal cancer or has other specified personal history presenting hazards to health.
- An examination indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding three years in a woman of childbearing age.

Woman of Childbearing Age

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

Covered Once Every 24 Months

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

Calculating Frequency

When calculating frequency to determine the 11-month period, the count starts beginning with the month after the month in which a previous test was performed. Follow the same procedure to calculate frequency for the 23-month period.

EXAMPLE: The beneficiary received a screening Pap test in January 2010. The count starts beginning February 2010. The beneficiary is eligible to receive another screening Pap test in January 2011 (the month after 11 months have passed).

Coinsurance or Copayment and Deductible

Medicare provides coverage for a screening Pap test as a Medicare Part B benefit. The coinsurance or copayment and deductible are described below in Reimbursement Information.

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

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

Table 1 – HCPCS Codes for Screening Pap Tests

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

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

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

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

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

Table 3 – HCPCS Code for Laboratory Specimen of Screening Pap Tests

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

Diagnosis Requirements

Medicare providers must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening (“V”) diagnosis codes, listed in Tables 4 and 5, for a screening Pap test. Code selection depends on whether the beneficiary is classified as low risk or high risk. The provider must report this diagnosis code, along with other applicable diagnosis codes.

Table 4 – Diagnosis Codes for Low Risk Screening Pap Tests

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

Table 5 – Diagnosis Code for High Risk Screening Pap Tests

High Risk ICD-9-CM Diagnosis Code	Code Descriptor
V15.89	Other specified personal history representing hazards to health

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS code and the corresponding ICD-9-CM diagnosis code in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for screening Pap tests when submitted on the following TOBs and associated revenue codes, listed in Table 6.

Table 6 – Facility Types, TOBs, and Revenue Codes for Screening Pap Tests*

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X	0311
Hospital Outpatient	13X	0311
Hospital Non-Patient Laboratory Specimens including CAH	14X	030X
Skilled Nursing Facility (SNF) Inpatient Part B**	22X	0311

Facility Type	Type of Bill	Revenue Code
SNF Outpatient	23X	0311
CAH Outpatient***	85X	0311
Rural Health Clinic (RHC)	71X	052X See Additional Billing Instructions for RHCs and FQHCs
Federally Qualified Health Center (FQHC)	77X	052X See Additional Billing Instructions for RHCs and FQHCs

***NOTE:** Revenue code 0923 must be used for billing HCPCS code Q0091 listed in Table 3.

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for screening Pap tests for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Screening Pap tests provided by other facility types must be reimbursed by the SNF.

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

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

For dates of service on or after July 1, 2009, a CAH will be paid 101 percent of reasonable costs for outpatient clinical diagnostic laboratory tests, and the beneficiary is no longer required to be physically present in a CAH at the time the specimen is collected. However, the beneficiary must be an outpatient of the CAH and be receiving services directly from the CAH. In order for the beneficiary to be receiving services directly from the CAH, the beneficiary must either be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or an entity that is provider-based to the CAH.

Additional Billing Instructions for RHCs and FQHCs

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

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

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

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

Coding Tip

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

- **Technical Component** for Independent RHCs and FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component for Dates of Service Prior to January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a physician or qualified non-physician practitioner furnishes a screening Pap test within an RHC/FQHC, the screening is considered an RHC/FQHC service. The provider of a screening Pap test must bill the FI/AB MAC under TOB 71X or 77X, respectively. The professional portion of the service is billed to the FI/AB MAC using revenue code 052X.
- **Professional Component for Dates of Service on or After January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - Detailed HCPCS coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The RHC/FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment (and deductible for RHCs). An additional line with revenue code 052X should be submitted with the appropriate HCPCS code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive encounter rate, and coinsurance or copayment and deductible will not apply.
  - If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/Current Procedural Terminology (CPT) code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.

Reimbursement Information

General Information

Medicare provides coverage for the screening Pap test as a Medicare Part B benefit. The coinsurance or copayment and deductible are described below in Reimbursement of Claims by Carriers/AB MACs and Reimbursement of Claims by FIs/AB MACs.

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses the screening Pap test service under the Clinical Laboratory Fee Schedule or the Medicare Physician Fee Schedule (MPFS).

Medicare Physician Fee Schedule (MPFS) Information

For more information about the MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

- For screening Pap test services paid under the MPFS (Tables 2 and 3), the coinsurance or copayment applies and the Medicare Part B deductible is waived. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived. **As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all screening Pap test services.**
- For screening Pap test services paid under the Clinical Laboratory Fee Schedule (Table 1), the coinsurance or copayment and the Medicare Part B deductible are waived when billed to the carrier/AB MAC.

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

Clinical Laboratory Fee Schedule Information

For more information about the Clinical Laboratory Fee Schedule, visit http://www.cms.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the screening Pap test depends on the type of facility providing the service. Tables 7 and 8 list the type of payment that facilities receive for screening Pap tests. Medicare bases reimbursement for most screening Pap test services on the Clinical Laboratory Fee Schedule or the MPFS, except for HCPCS code Q0091 as described in Table 8.

- For screening Pap test services paid under the MPFS (Tables 2 and 3) and HCPCS code Q0091 billed to the FI/AB MAC, the coinsurance or copayment applies and the Medicare Part B deductible is waived. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.
- For screening Pap test services paid under the Clinical Laboratory Fee Schedule (Table 1) billed to the FI/AB MAC, the coinsurance or copayment and Medicare Part B deductible are waived.

Table 7 – Facility Payment Methodology for Screening Pap Tests

Facility Type	Basis of Payment
Hospital	HCPCS codes listed in Table 1 paid under the Clinical Laboratory Fee Schedule HCPCS codes listed in Table 2 paid under the Medicare Physician Fee Schedule (MPFS)
Skilled Nursing Facility (SNF)*	MPFS
Critical Access Hospital (CAH)	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services
Rural Health Clinic (RHC)	All-Inclusive Encounter Rate
Federally Qualified Health Center (FQHC)	All-Inclusive Encounter Rate

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for screening Pap tests for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Screening Pap tests provided by other facility types must be reimbursed by the SNF.

Table 8 – Facility Payment Methodology for HCPCS Code Q0091

Facility Type	Basis of Payment
Hospital Outpatient Department	Outpatient Prospective Payment System (OPPS)
Skilled Nursing Facility (SNF)*	Medicare Physician Fee Schedule (MPFS)
Critical Access Hospital (CAH)	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services
Rural Health Clinic (RHC)	All-Inclusive Encounter Rate
Federally Qualified Health Center (FQHC)	All-Inclusive Encounter Rate

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for screening Pap tests for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Screening Pap tests provided by other facility types must be reimbursed by the SNF.

Outpatient Prospective Payment System (OPPS) Information

For more information about OPPS, visit http://www.cms.gov/HospitalOutpatientPPS on the CMS website.

Reasons for Claim Denial

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

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

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Screening Pap Tests

Resources

American Cancer Society Learn About Cervical Cancer
http://www.cancer.org/cancer/cervicalcancer

Centers for Disease Control and Prevention (CDC) Cervical Cancer Information
http://www.cdc.gov/cancer/cervical

CMS Cervical Cancer Screening Web Page
http://www.cms.gov/CervicalCancerScreening

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

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

Medicare Learning Network® (MLN) "Cancer Screenings" Brochure (ICN 006434)
http://www.cms.gov/MLNProducts/downloads/Cancer_Screening.pdf

"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.2
http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

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

National Cancer Institute Cervical Cancer Information
http://www.cancer.gov/cancertopics/types/cervical

USPSTF Recommendations
This website provides the USPSTF written recommendations on screening for cervical cancer.
http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm

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More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes

Notes

Chapter 10
Screening Pelvic Examination

Overview

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

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible for the screening pelvic examination are waived under the Affordable Care Act.

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

Coverage Information

Medicare provides coverage of a screening pelvic examination for all female beneficiaries by a doctor of medicine or osteopathy or other authorized qualified non-physician 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 (this examination does not have to be ordered by a physician or other authorized practitioner). Frequency of coverage is provided below.

Covered Once Every 24 Months

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

Covered Once Every 12 Months

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

- Evidence (medical history or other findings) shows that the woman is in one of the high risk categories (identified below) for developing cervical or vaginal cancer.
- An examination indicated the presence of cervical or vaginal cancer or other abnormality during the preceding three years in a woman of childbearing age.

Woman of Childbearing Age

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

For purposes of this benefit, high risk categories for cervical and vaginal cancer include the following:

- 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 HPV and/or Human Immunodeficiency Virus [HIV] infection),
- Fewer than three negative Pap tests or no Pap test within the previous seven years, and
- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

Calculating Frequency

When calculating frequency to determine the 11-month period, the count starts beginning with the month after the month in which a previous test was performed. Follow the same procedure to calculate frequency for the 23-month period.

EXAMPLE: The beneficiary in a high risk category received a screening pelvic examination in January 2010. The count starts beginning February 2010. The beneficiary is eligible to receive another screening pelvic examination in January 2011 (the month after 11 months have passed).

Stand Alone Benefit

The screening pelvic examination benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

Screening Pelvic Examination Elements

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

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;
- External genitalia (for example, general appearance, hair distribution, or lesions);
- Urethral meatus (for example, size, location, lesions, or prolapse);
- Urethra (for example, masses, tenderness, or scarring);
- Bladder (for example, fullness, masses, or tenderness);
- Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
- Cervix (for example, general appearance, lesions, or discharge);

- Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
- Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); or
- Anus and perineum.

Coinsurance or Copayment and Deductible

Medicare provides coverage for the screening pelvic examination as a Medicare Part B benefit. The coinsurance or copayment applies to this benefit. The Medicare Part B deductible is waived. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) code, listed in Table 1, must be used to report screening pelvic examinations.

Table 1 – HCPCS Code for the Screening Pelvic Examinations

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

Diagnosis Requirements

Medicare providers must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening ("V") diagnosis codes, listed in Tables 2 and 3, for a screening pelvic examination and/or screening Pap test. Code selection depends on whether the beneficiary is classified as low risk or high risk. Other applicable diagnosis codes must also be reported.

Table 2 – Diagnosis Codes for Low Risk Screening Pelvic Examinations

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

Table 3 – Diagnosis Code for High Risk Screening Pelvic Examinations

High Risk ICD-9-CM Diagnosis Code	Code Descriptor
V15.89	Other specified personal history representing hazards to health

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report HCPCS code G0101 and the corresponding ICD-9-CM diagnosis code in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. Additional information on these formats is available at http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report HCPCS code G0101, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for screening pelvic examinations when submitted on the following TOBs and associated revenue codes, listed in Table 4.

Table 4 – Facility Types, TOBs, and Revenue Codes for Screening Pelvic Examinations

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X	0770
Hospital Outpatient	13X	0770
Skilled Nursing Facility (SNF) Inpatient Part B*	22X	0770
SNF Outpatient	23X	0770
CAH**	85X	0770
Rural Health Clinic (RHC)	71X	052X See Additional Billing Instructions for RHCs and FQHCs
Federally Qualified Health Center (FQHC)	77X	052X See Additional Billing Instructions for RHCs and FQHCs

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for screening pelvic examinations for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Screening pelvic examinations provided by other facility types must be reimbursed by the SNF.

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

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

Additional Billing Instructions for RHCs and FQHCs

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

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

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

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

Coding Tip

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

- **Technical Component** for Independent RHCs and FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component for Dates of Service Prior to January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a physician or qualified non-physician practitioner furnishes a screening pelvic examination within an RHC/FQHC, the screening is considered an RHC/FQHC service. The provider of a screening pelvic examination service must bill the FI/AB MAC under TOB 71X or 77X, respectively. The professional portion of the service is billed to the FI/AB MAC using revenue code 052X.
- **Professional Component for Dates of Service on or After January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - Detailed HCPCS coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The RHC/FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment (and deductible for RHCs). An additional line with revenue code 052X should be submitted with the appropriate HCPCS code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive encounter rate, and coinsurance or copayment and deductible will not apply.
  - If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/Current Procedural Terminology (CPT) code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.

Reimbursement Information

General Information

Medicare provides coverage for the screening pelvic examination as a Medicare Part B benefit. The coinsurance or copayment applies to this benefit. The Medicare Part B deductible is waived. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses the screening pelvic examination service under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all screening pelvic examinations.

Medicare Physician Fee Schedule (MPFS) Information

For more information about the MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the screening pelvic examination depends on the type of facility providing the service. Table 5 lists the type of payment that facilities receive for screening pelvic examinations.

National Correct Coding Initiative (NCCI) Edits

Refer to the currently applicable bundled carrier processed procedures at http://www.cms.gov/NationalCorrectCodInitEd on the CMS website.

Table 5 – Facility Payment Methodology for Screening Pelvic Examinations

Facility Type	Basis of Payment
Hospital	Outpatient Prospective Payment System (OPPS)
Skilled Nursing Facility (SNF)*	Medicare Physician Fee Schedule (MPFS)
Critical Access Hospital (CAH)	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services
Rural Health Clinic (RHC)	All-Inclusive Encounter Rate
Federally Qualified Health Center (FQHC)	All-Inclusive Encounter Rate

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for screening pelvic examinations for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Screening pelvic examinations provided by other facility types must be reimbursed by the SNF.

Outpatient Prospective Payment System (OPPS) Information

For more information about OPPS, visit http://www.cms.gov/HospitalOutpatientPPS on the CMS website.

Reasons for Claim Denial

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

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Screening Pelvic Examination

Resources

American Cancer Society Learn About Cervical Cancer
http://www.cancer.org/cancer/cervicalcancer

Centers for Disease Control and Prevention (CDC) Cervical Cancer Information
http://www.cdc.gov/cancer/cervical

CMS Cervical Cancer Screening Web Page
http://www.cms.gov/CervicalCancerScreening

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 40
http://www.cms.gov/manuals/downloads/clm104c18.pdf

Medicare Learning Network® (MLN) "Cancer Screenings" Brochure (ICN 006434)
http://www.cms.gov/MLNProducts/downloads/Cancer_Screening.pdf

"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.2
http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

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

National Cancer Institute Cervical Cancer Information
http://www.cancer.gov/cancertopics/types/cervical

USPSTF Recommendations
This website provides the USPSTF written recommendations on screening for cervical cancer.
http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm

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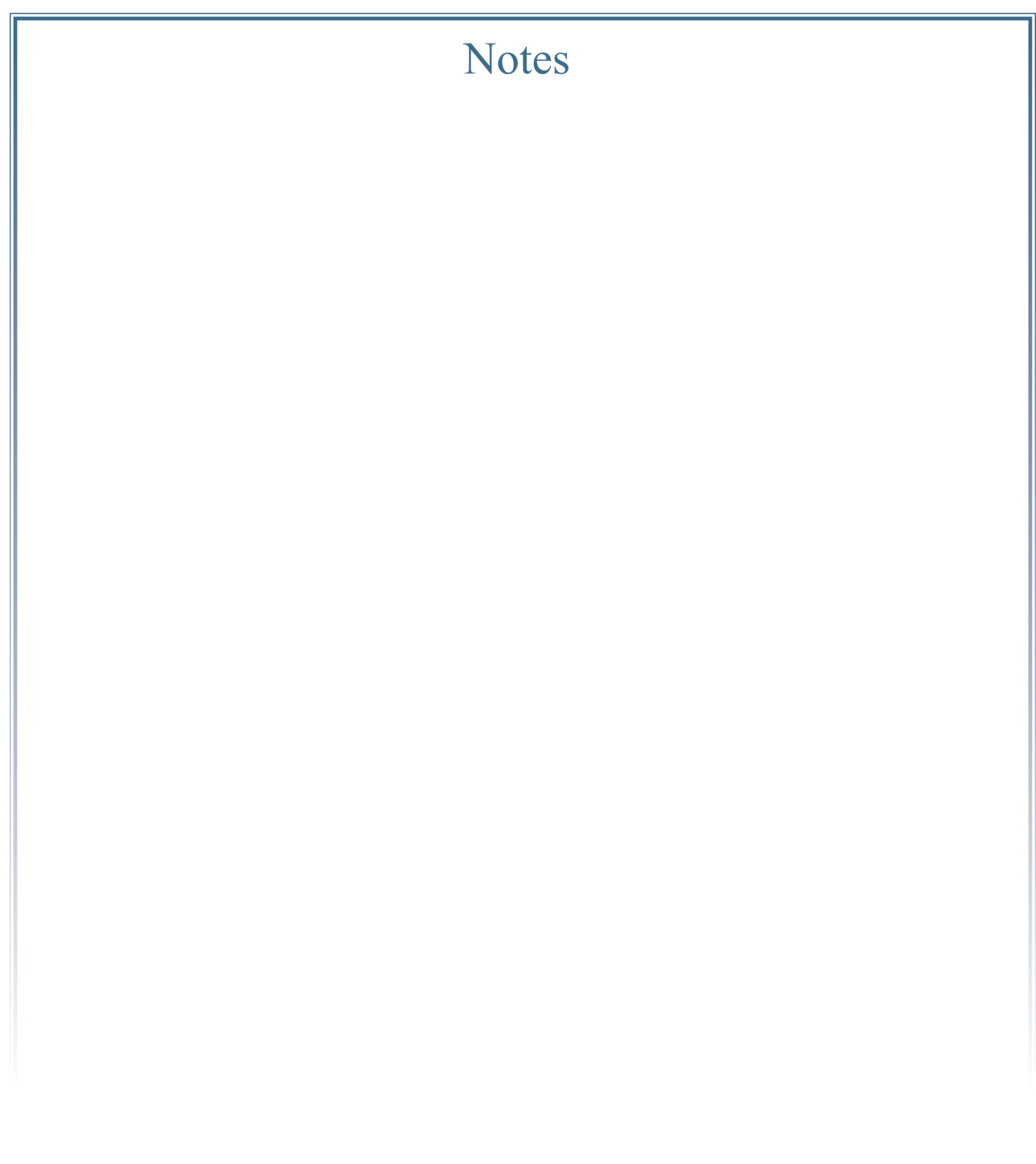
More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.



Notes

Chapter 11
Colorectal Cancer Screening

Overview

Individuals with colorectal cancer rarely display any symptoms, and the cancer can progress unnoticed and untreated until it becomes fatal. The most common symptom of colorectal cancer is bleeding from the rectum. Other common symptoms include cramps, abdominal pain, intestinal obstruction, or a change in bowel habits.

Colorectal cancer is largely preventable through screening, which can find pre-cancerous polyps (growths in the colon) that can be removed before they develop into cancer. Screening can also detect cancer early when it is easier to treat and cure. Screenings are performed to diagnose colorectal cancer or to determine a beneficiary's risk for developing colorectal cancer. Colorectal cancer screening may consist of several different screening services to test for polyps or colorectal cancer. Each colorectal cancer screening can be used alone or in combination.

Medicare provides coverage of the following colorectal cancer screening services for the early detection of colorectal cancer:

- Fecal Occult Blood Test (FOBT),
- Flexible Sigmoidoscopy,
- Colonoscopy, and
- Barium Enema (as an alternative to a covered screening flexible sigmoidoscopy or a screening colonoscopy).

NOTE: At this time, Medicare does not cover screening deoxyribonucleic acid (DNA) stool tests as part of the colorectal cancer screening benefit.

The **Fecal Occult Blood Test (FOBT)** checks for occult or hidden blood in the stool. A Medicare provider gives an FOBT card to the beneficiary, and the beneficiary can perform the test at home. The beneficiary takes stool samples, places them on the test cards, and then returns the test cards to the doctor or a laboratory. The FOBT consists of either one of two types of tests:

1. FOBT, 1-3 Simultaneous Determinations – A guaiac-based test for peroxidase activity, which the beneficiary completes by taking samples from two different sites of three consecutive stools; or

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

The coinsurance or copayment and deductible for Fecal Occult Blood Tests (FOBTs) are already waived and are not affected by the Affordable Care Act.

For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible for flexible sigmoidoscopies and colonoscopies are waived under the Affordable Care Act.

The coinsurance or copayment and deductible for barium enemas are not waived. The USPSTF has not rated barium enemas, so the Affordable Care Act does not waive the coinsurance or copayment or deductible.

The Affordable Care Act waives the Medicare Part B deductible for colorectal cancer screening tests that turn diagnostic in connection with, as a result of, and in the same clinical encounter as the screening test.

The Affordable Care Act revised the list of preventive services paid by Medicare in the Federally Qualified Health Center (FQHC) setting. For dates of service on or after January 1, 2011, the professional component of colorectal cancer screenings is a covered FQHC service when provided by an FQHC.

2. Immunoassay, FOBT, 1-3 Simultaneous Determinations – An immunoassay (or immunochemical) test for antibody activity, which the beneficiary completes by taking the appropriate number of samples according to the specific manufacturer's instructions.

The **flexible sigmoidoscopy** is a procedure used to check for polyps and cancer. It is administered using a thin, flexible, lighted tube called a sigmoidoscope that provides direct visualization of the rectum and lower third of the colon. The procedure allows for biopsies of polyps and cancers to be taken as well as polyp removal.

The **colonoscopy** is a procedure similar to the flexible sigmoidoscopy, except a longer, thin, flexible, lighted tube called a colonoscope is used to provide direct visualization of the rectum and the entire colon. This procedure is used to check for polyps and cancer in the rectum and the entire colon. Most polyps and some cancers can be found and removed during the procedure.

The **barium enema** is an X-ray examination of the large intestine. To make the intestine visible on an X-ray picture, the colon is filled with a contrast material containing barium to check for polyps or other abnormalities.

Risk Factors

Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of familial adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

Coverage Information

Medicare provides coverage of colorectal cancer screening for the early detection of colorectal cancer. All Medicare beneficiaries aged 50 and older are covered; however, when a beneficiary is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema rendered as an alternative to a screening colonoscopy.

Stand Alone Benefit

The colorectal cancer screening benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

Medicare provides coverage for colorectal cancer screening as a Medicare Part B benefit. The coinsurance or copayment and deductible are described in Table 9.

The following are the coverage criteria for each colorectal cancer screening test/procedure.

Screening FOBT

Medicare provides coverage of a screening FOBT annually (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed) for beneficiaries aged 50 and older. This screening requires a written order from the beneficiary's attending physician.

NOTE: Payment may be made for an immunoassay-based FOBT (Healthcare Common Procedure Coding System [HCPCS] code G0328) as an alternative to the guaiac-based FOBT (Common Procedural Terminology [CPT] code 82270). However, Medicare will only provide coverage for one FOBT per year: either HCPCS code G0328 or CPT code 82270, but not both.

NOTE: To ensure that Medicare and Medicaid only pay for a laboratory test categorized as waived complexity under the Clinical Laboratory Improvement Amendments (CLIA), for dates of service on or after April 5, 2010, HCPCS code G0328 must be billed with modifier -QW to be recognized as a waived test.

Who Can Order the Screening FOBT?

The screening FOBT requires a written order from the beneficiary's attending physician. Attending physician means a doctor of medicine or osteopathy who is fully knowledgeable about the beneficiary's medical condition and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

Screening Flexible Sigmoidoscopy

Medicare provides coverage of a screening flexible sigmoidoscopy (HCPCS code G0104) for beneficiaries aged 50 and older, without regard to risk.

Who Can Perform a Screening Flexible Sigmoidoscopy?

Screening flexible sigmoidoscopies must be performed by a doctor of medicine or osteopathy, a physician assistant, nurse practitioner, or clinical nurse specialist.

<u>For Beneficiaries at High Risk for Developing Colorectal Cancer</u>

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.

<u>For Beneficiaries Not at High Risk for Developing Colorectal Cancer</u>

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 aged 50 and older, unless the beneficiary does not meet the high risk criteria for developing colorectal cancer and the beneficiary has had a screening colonoscopy (HCPCS code G0121) within the preceding 10 years. If the beneficiary has had a screening colonoscopy within the preceding 10 years, then the next screening flexible sigmoidoscopy will be covered only after at least 119 months have passed following the month in which the last covered screening colonoscopy (HCPCS code G0121) was performed.

NOTE: If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed, rather than HCPCS code G0104. For dates of service on or after January 1, 2011, the deductible is waived for colorectal cancer screening tests that become diagnostic. Modifier -PT should be appended to the diagnostic procedure code that is reported instead of the screening flexible sigmoidoscopy HCPCS code. This assures that the deductible is waived for all surgical services on the same date as the diagnostic test.

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Screening Colonoscopy

Medicare provides for coverage of a screening colonoscopy (HCPCS code G0105 or G0121) for all beneficiaries without regard to age. A doctor of medicine or osteopathy must perform this screening.

> **Who Can Perform a Screening Colonoscopy?**
>
> Screening colonoscopies must be performed by a doctor of medicine or osteopathy.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening colonoscopy (HCPCS code G0105) once every 2 years for beneficiaries at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered screening colonoscopy [HCPCS code G0105] was performed).

NOTE: If during the course of the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed, rather than HCPCS code G0105. For dates of service on or after January 1, 2011, the deductible is waived for colorectal cancer screening tests that become diagnostic. Modifier -PT should be appended to the diagnostic procedure code that is reported instead of the screening colonoscopy HCPCS code. This assures that the deductible is waived for all surgical services on the same date as the diagnostic test.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening colonoscopy (HCPCS code G0121) for beneficiaries who do not meet the criteria for being at high risk for developing colorectal cancer once every 10 years (i.e., at least 119 months have passed following the month in which the last covered screening colonoscopy [HCPCS code G0121] was performed). If the beneficiary otherwise qualifies to have a covered screening colonoscopy (HCPCS code G0121) based on the above but has had a covered screening flexible sigmoidoscopy (HCPCS code G0104), then Medicare may cover a screening colonoscopy (HCPCS code G0121) only after at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy (HCPCS code G0104) was performed.

NOTE: If during the course of the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed, rather than HCPCS code G0121. For dates of service on or after January 1, 2011, the deductible is waived for colorectal cancer screening tests that become diagnostic. Modifier -PT should be appended to the diagnostic procedure code that is reported instead of the screening colonoscopy HCPCS code. This assures that the deductible is waived for all surgical services on the same date as the diagnostic test.

Screening Barium Enema

Medicare provides coverage of a screening barium enema examination (HCPCS code G0106 or G0120) as an alternative to either a high risk screening colonoscopy (HCPCS code G0105) or a screening flexible sigmoidoscopy (HCPCS code G0104).

> **Who Can Order a Screening Barium Enema?**
>
> The screening barium enema must be ordered by a doctor of medicine or osteopathy.

For Beneficiaries at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening barium enema (HCPCS code G0120) as an alternative to a screening colonoscopy (HCPCS code G0105) every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening barium enema or the last screening colonoscopy was performed)

for beneficiaries at high risk for colorectal cancer, without regard to age. The same frequency parameters for screening colonoscopies apply.

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

Medicare provides coverage of a screening barium enema (HCPCS code G0106) as an alternative to a screening flexible sigmoidoscopy (HCPCS code G0104) once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening barium enema or screening flexible sigmoidoscopy was performed) for beneficiaries not at high risk for colorectal cancer, but who are aged 50 or older. The same frequency parameters for screening sigmoidoscopies apply.

The screening barium enema (preferably a double contrast barium enema) must be ordered in writing after a determination that the procedure is appropriate. If the beneficiary 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 beneficiary. 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.

For dates of service on or after January 1, 2011, if a colorectal cancer screening service is performed as a result of a barium enema and becomes diagnostic, the deductible is waived for all surgical services provided on that date. Modifier -PT should be appended to the diagnostic procedure code that is reported instead of the screening HCPCS code. This assures that the deductible is waived for all surgical services on the same date as the diagnostic test.

Screening Colorectal Cancer Tests that Turn Diagnostic in the Same Clinical Encounter

When colorectal cancer screening tests become diagnostic, providers will append modifier -PT (Colorectal cancer screening test, converted to diagnostic test or other procedure) to the diagnostic test or other procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes diagnostic.

The claims processing system will respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance or copayment would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

Non-Covered Colorectal Cancer Screening Services

Medicare covers colorectal barium enemas only in lieu of covered screening flexible sigmoidoscopies (HCPCS code G0104) or covered screening colonoscopies (HCPCS code G0105). However, there may be instances when the beneficiary elects to receive the barium enema for colorectal screening other than specifically for these purposes. In such situations, the beneficiary may require a formal denial of the service from Medicare in order to bill a supplemental insurer who may cover the service. These non-covered barium enemas are to be identified by HCPCS code G0122 (colorectal cancer screening; barium enema). Medicare providers should not use HCPCS code G0122 for covered barium enema services; that is, those rendered in place of the covered screening colonoscopy or covered flexible sigmoidoscopy. The beneficiary is liable for payment of the non-covered barium enema.

Documentation

Documentation in the beneficiary's medical record must identify any risk factors for tests/procedures performed.

When a covered procedure is attempted and unable to be completed, Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event the Medicare Contractor needs the information to document the incomplete procedure.

If a screening barium enema is provided, the documentation should reflect that the procedure was performed:

- As an alternative to either a screening flexible sigmoidoscopy or a high risk screening colonoscopy, and
- Because it was determined that the screening potential for the barium enema was equal to or greater than the estimated screening potential for a screening flexible sigmoidoscopy or for a screening colonoscopy, as appropriate, for the same beneficiary.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following HCPCS/CPT codes, listed in Table 1, must be used to report colorectal cancer screening.

Table 1 – HCPCS/CPT Codes for Colorectal Screening

HCPCS/CPT Code	Code Descriptor
G0104	Colorectal cancer screening; flexible sigmoidoscopy
G0105	Colorectal cancer screening; colonoscopy on individual at high risk
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection)
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0328*	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous

***NOTE:** To ensure that Medicare and Medicaid only pay for a laboratory test categorized as waived complexity under CLIA, for dates of service on or after April 5, 2010, HCPCS code G0328 must be billed with modifier -QW to be recognized as a waived test.

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Diagnosis Requirements

For the screening colonoscopy, the beneficiary is not required to have any present signs/symptoms. However, when Medicare providers bill for the "high risk" beneficiary, the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening diagnosis code on the claim must reflect at least one of the high risk conditions described previously.

Listed in Tables 2, 3, and 4 are examples of ICD-9-CM codes for 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 Diagnosis Code	Code Descriptor
V10.05	Personal history of malignant neoplasm of large intestine
V10.06	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

Table 3 – Chronic Digestive Disease Condition ICD-9-CM Codes

ICD-9-CM Diagnosis Code	Code Descriptor
555.0	Regional enteritis of small intestine
555.1	Regional enteritis of large intestine
555.2	Regional enteritis of small intestine with large intestine
555.9	Regional enteritis of unspecified site
556.0	Ulcerative (chronic) enterocolitis
556.1	Ulcerative (chronic) ileocolitis
556.2	Ulcerative (chronic) proctitis
556.3	Ulcerative (chronic) proctosigmoiditis
556.8	Other ulcerative colitis
556.9	Ulcerative colitis, unspecified

Table 4 – Inflammatory Bowel ICD-9-CM Codes

ICD-9-CM Diagnosis Code	Code Descriptor
558.2	Toxic gastroenteritis and colitis
558.9	Other and unspecified noninfectious gastroenteritis and colitis

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT codes and the corresponding ICD-9-CM diagnosis code in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit those claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the Centers for Medicare & Medicaid Services (CMS) website.

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The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT codes, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit those claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for colorectal cancer screening when submitted on the following TOBs and associated revenue codes, listed in Table 5.

Table 5 – Facility Types, TOBs, and Revenue Codes for Colorectal Cancer Screening Services*

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	See Table 6
Hospital Non-Patient Laboratory Specimens**	14X	030X for HCPCS G0328*** or CPT 82270
Skilled Nursing Facility (SNF) Inpatient Part B	22X	See Table 7
SNF Outpatient	23X	See Table 7
Ambulatory Surgical Center (ASC)	83X	030X for HCPCS G0328 or CPT 82270 The appropriate revenue code when reporting any other surgical procedure for HCPCS G0104, G0105, G0121
Critical Access Hospital (CAH)****	85X	See Table 6
Federally Qualified Health Center (FQHC) for dates of service on or after January 1, 2011	77X	052X

***NOTE:** For dates of service on or after October 1, 2010, use TOB 12X in place of TOB 13X to bill for colorectal cancer screening services provided to hospital inpatients under Medicare Part B, or when Part A benefits have been exhausted. This applies for services billed using HCPCS/CPT codes 82270, G0104, G0105, G0106, G0120, G0121, G0122, or G0328.

****NOTE:** All hospitals submitting claims containing CPT code 82270 and HCPCS code G0328 for non-patient laboratory specimens should use TOB 14X.

*****NOTE:** To ensure that Medicare and Medicaid only pay for a laboratory test categorized as waived complexity under CLIA, for dates of service on or after April 5, 2010, HCPCS code G0328 must be billed with modifier -QW to be recognized as a waived test.

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

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, or 098X. **(This pertains to physicians/ non-physician practitioners who have reassigned their billing rights to the Method II CAH.)** For the technical component, use revenue code 075X or another appropriate revenue code.

For dates of service on or after July 1, 2009, a CAH will be paid 101 percent of reasonable costs for outpatient clinical diagnostic laboratory tests, and the beneficiary is no longer required to be physically present in a CAH at the time the specimen is collected. However, the beneficiary must be an outpatient of the CAH and be receiving services directly from the CAH. In order for the beneficiary to be receiving services directly from the CAH, the beneficiary must either be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or an entity that is provider-based to the CAH.

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Additional Billing Instructions for Hospitals, CAHs, and ASCs

When these tests/procedures are provided to inpatients of a hospital, the inpatients are covered under this benefit. However, the Medicare provider should bill on TOB 13X using the discharge date of the hospital stay to avoid editing.

For dates of service on or after October 1, 2010, use TOB 12X in place of TOB 13X to bill for colorectal cancer screening provided to hospital inpatients under Part B, or when Part A benefits have been exhausted. This applies for services billed using HCPCS/CPT codes 82270, G0104, G0105, G0106, G0120, G0121, or G0328.

Table 6 lists revenue codes and HCPCS/CPT codes for each procedure, to be reported on a 12X, 13X, 83X, or 85X TOB, as applicable.

National Correct Coding Initiative (NCCI) Edits

Refer to the currently applicable bundled carrier processed procedures at http://www.cms.gov/NationalCorrectCodInitEd on the CMS website.

Table 6 – Procedure, Revenue Code, and Associated HCPCS/CPT Codes for Facilities Using TOBs 12X, 13X, 83X, and 85X*

Screening Test/Procedure	Revenue Code	HCPCS/CPT Code
Fecal Occult Blood Test	030X	82270, G0328**
Barium Enema	032X	G0106, G0120 (G0122 non-covered)
Flexible Sigmoidoscopy	The appropriate revenue code when reporting any other surgical procedure for TOBs 12X, 13X, 83X, or 85X	G0104
Colonoscopy – High Risk	The appropriate revenue code when reporting any other surgical procedure for TOBs 12X, 13X, 83X, or 85X	G0105, G0121

***NOTE:** Hospital and CAH providers should submit TOBs 12X, 13X, or 85X. Outpatient surgery performed by a hospital not bound by the Outpatient Prospective Payment System (OPPS) requirements should be submitted on a TOB 83X.

****NOTE:** To ensure that Medicare and Medicaid only pay for a laboratory test categorized as waived complexity under CLIA, for dates of service on or after April 5, 2010, HCPCS code G0328 must be billed with modifier -QW to be recognized as a waived test.

Additional Billing Instructions for SNFs

The SNF consolidated billing provision allows separate Medicare Part B payment for colorectal cancer screening tests for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Colorectal cancer screening tests provided by other facility types must be reimbursed by the SNF.

Table 7 lists revenue codes and HCPCS/CPT codes for each procedure, to be reported by the SNF on a 22X TOB or a 23X TOB, as applicable.

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

Screening Test/Procedure	Revenue Code	HCPCS/CPT Code
Fecal Occult Blood Test	030X	82270
Fecal Occult Blood Test, Immunoassay	030X	G0328*
Barium Enema	032X	G0106, G0120 (G0122 non-covered)
Flexible Sigmoidoscopy	The appropriate revenue code when reporting any other surgical procedure	G0104, G0105, G0121

***NOTE:** To ensure that Medicare and Medicaid only pay for a laboratory test categorized as waived complexity under CLIA, for dates of service on or after April 5, 2010, HCPCS code G0328 must be billed with modifier -QW to be recognized as a waived test.

Additional Billing Instructions for FQHCs for Dates of Service on or After January 1, 2011

The Affordable Care Act revised the list of preventive services paid by Medicare in the FQHC setting. For dates of service on or after January 1, 2011, the professional component of colorectal cancer screenings is a covered FQHC service when provided by an FQHC. FQHCs should follow these 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.

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

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

- **Technical Component** for Provider-Based FQHCs:
  - The base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **Technical Component** for Independent FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component** for Provider-Based FQHCs and Freestanding FQHCs:
  - Detailed HCPCS coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment. An additional line with revenue code 052X should be submitted with the appropriate HCPCS code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive encounter rate, and coinsurance or copayment and deductible will not apply.

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- If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/CPT code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.

Reimbursement Information

General Information

Medicare provides coverage for colorectal cancer screening as a Medicare Part B benefit. The coinsurance or copayment and deductible are described in Table 9.

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses for colorectal screening under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all colorectal screening services.

Medicare Physician Fee Schedule (MPFS) Information

For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Medicare makes payment to ASCs for facility services furnished in connection with colorectal screening procedures (included on the ASC list of covered surgical procedures) under the ASC fee schedule when billed to the carrier/AB MAC.

Reimbursement for FOBTs is paid under the Clinical Laboratory Fee Schedule, with the exception of CAHs, which are paid on a reasonable cost basis.

Clinical Laboratory Fee Schedule

For more information about the Clinical Laboratory Fee Schedule, visit http://www.cms.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Reimbursement by Carriers/AB MACs of Interrupted and Completed Colonoscopies

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay the physician for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy HCPCS code with modifier -53 to indicate that the procedure was interrupted.

When a covered colonoscopy is attempted in an ASC and is discontinued due to extenuating circumstances that threaten the well-being of the beneficiary prior to the administration of anesthesia, but after the beneficiary has been taken to the procedure room, the ASC is to suffix the colonoscopy HCPCS code with modifier -73. 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 beneficiary, the ASC is to suffix the colonoscopy HCPCS code with modifier -74. The procedure will be paid at the full amount.

Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event that the Medicare Contractor needs it to document the incomplete procedure.

When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met. This policy is applied to both screening and diagnostic colonoscopies.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for colorectal cancer screening procedures depends on the type of facility providing the service. Table 8 lists the type of payment that facilities receive for colorectal screening.

Table 8 – Facility Payment Methodology for Colorectal Cancer Screening

Type of Colorectal Screening	Facility	Basis of Payment
Fecal Occult Blood Tests (82270 and G0328*)	Critical Access Hospital (CAH)	Reasonable Cost Basis
Fecal Occult Blood Tests (82270 and G0328*)	All other types of facilities	Clinical Laboratory Fee Schedule (Medicare pays the lower of 100% of the Clinical Laboratory Fee Schedule amount or the provider's actual charge)
Flexible Sigmoidoscopy (G0104**)	CAH	Reasonable Cost Basis
Flexible Sigmoidoscopy (G0104**)	Hospital Outpatient Department	Outpatient Prospective Payment System (OPPS)
Flexible Sigmoidoscopy (G0104**)	Skilled Nursing Facility (SNF) Inpatient Part B	Medicare Physician Fee Schedule (MPFS)
Colonoscopy (G0105 and G0121)	CAH	Reasonable Cost Basis
Colonoscopy (G0105 and G0121)	Hospital Outpatient Department	OPPS
Barium Enemas (G0106 and G0120)	CAH	Reasonable Cost Basis
Barium Enemas (G0106 and G0120)	Hospital Outpatient Department	OPPS
Barium Enemas (G0106 and G0120)	SNF	MPFS

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

***NOTE:** To ensure that Medicare and Medicaid only pay for a laboratory test categorized as waived complexity under CLIA, for dates of service on or after April 5, 2010, HCPCS code G0328 must be billed with modifier -QW to be recognized as a waived test.

Outpatient Prospective Payment System (OPPS) Information

For more information about OPPS, visit http://www.cms.gov/HospitalOutpatientPPS on the CMS website.

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****NOTE:** Colorectal cancer screening flexible sigmoidoscopies (HCPCS code G0104) are payable in ASCs. The deductible does not apply for the screening, and the beneficiary pays 25 percent of the Medicare-approved amount. For dates of service on or after January 1, 2011, both coinsurance or copayment and deductible are waived.

Table 9 – Coinsurance or Copayment and Medicare Part B Deductible for Colorectal Cancer Screening*

Type of Colorectal Screening	Dates of Service Prior to January 1, 2011	Dates of Service on or After January 1, 2011
Fecal Occult Blood Tests (82270 and G0328**)	Both waived	Both waived
Flexible Sigmoidoscopy (G0104)	Coinsurance or copayment apply; except for screenings performed at a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount. The Medicare Part B deductible is waived.	Both waived
Colonoscopy (G0105 and G0121)	Coinsurance or copayment apply; except for screenings performed at a Critical Access Hospital (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. The Medicare Part B deductible is waived.	Both waived
Barium Enemas (G0106 and G0120)	Coinsurance or copayment apply; except for screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure. The Medicare Part B deductible is waived.	Coinsurance or copayment apply; except for screenings performed at a CAH, the beneficiary is not liable for costs associated with the procedure. The Medicare Part B deductible is waived.

***NOTE:** For dates of service prior to January 1, 2011, Medicare does not waive the deductible if the colorectal cancer screening test becomes a diagnostic colorectal test; that is, the service actually results in a biopsy or removal of a lesion or growth.

For dates of service on or after January 1, 2011, the deductible is waived for colorectal cancer screening tests that become diagnostic. Modifier -PT should be appended to the diagnostic procedure code that is reported instead of the screening code. This assures that the deductible is waived for all surgical services on the same date as the diagnostic test.

****NOTE:** To ensure that Medicare and Medicaid only pay for a laboratory test categorized as waived complexity under CLIA, for dates of service on or after April 5, 2010, HCPCS code G0328 must be billed with modifier -QW to be recognized as a waived test.

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Reimbursement by FIs/AB MACs of Interrupted and Completed Colonoscopies

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy as long as the coverage conditions are met for the incomplete procedure. The CWF will not apply the frequency standards associated with screening colonoscopies. When submitting a facility claim for the interrupted colonoscopy, providers are to suffix the colonoscopy HCPCS codes with modifier -73 or -74, as appropriate, to indicate that the procedure was interrupted. Medicare expects the provider to maintain adequate information in the beneficiary's medical record in the event that the Medicare Contractor needs it to document the incomplete procedure.

When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure, as long as coverage conditions are met. The frequency standards will be applied by the CWF. This policy is applied to both screening and diagnostic colonoscopies.

Reimbursement for CAHs by FIs/AB MACs of Interrupted and Completed Colonoscopies

In situations where a CAH has elected payment Method II, 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). Method II CAHs will also bill the technical component of the interrupted colonoscopy with revenue code 075X (or other appropriate revenue code) and modifier -73 or -74, as appropriate.

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of colorectal cancer screening:

- The beneficiary is aged 50 or younger.
- The beneficiary does not meet the criteria of being at high risk of developing colorectal cancer.
- The beneficiary has exceeded Medicare's frequency parameters for coverage of colorectal cancer screening services.

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Colorectal Cancer Screening

Resources

The American Cancer Society
"How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide"
http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf

The American Cancer Society's "ColonMD: Clinicians' Information Source"
http://www.cancer.org/Healthy/InformationforHealthCareProfessionals/ColonMDClinicansInformationSource

The American Cancer Society's Colorectal Cancer Facts & Figures
http://www.cancer.org/Research/CancerFactsFigures/ColorectalCancerFactsFigures

Centers for Disease Control and Prevention (CDC) Colorectal Cancer Web Page
http://www.cdc.gov/cancer/colorectal

CMS Colorectal Cancer Screening Web Page
http://www.cms.gov/ColorectalCancerScreening

"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 280.2
http://www.cms.gov/manuals/Downloads/bp102c15.pdf

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 60
http://www.cms.gov/manuals/downloads/clm104c18.pdf

Medicare Learning Network® (MLN) "Cancer Screenings" Brochure (ICN 006434)
http://www.cms.gov/MLNProducts/downloads/Cancer_Screening.pdf

MLN Matters® Article MM6578, "Screening Computed Tomography Colonography (CTC) for Colorectal Cancer"
http://www.cms.gov/MLNMattersArticles/downloads/MM6578.pdf

MLN Matters® Article MM6760, "Use of 12X Type of Bill for Billing Colorectal Screening Services"
http://www.cms.gov/MLNMattersArticles/downloads/MM6760.pdf

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

The National Cancer Institute's Colorectal Cancer Screening Fact Sheet
http://www.cancer.gov/cancertopics/factsheet/Detection/colorectal-screening

The National Cancer Institute's General Information About Colorectal Cancer
http://www.nci.nih.gov/cancertopics/pdq/prevention/colorectal/Patient/page2

USPSTF Colorectal Cancer Screening Recommendations
This website provides the USPSTF written recommendations.
http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm

What Are the Key Statistics for Colorectal Cancer?
A colorectal cancer fact sheet produced by the American Cancer Society
http://www.cancer.org/Cancer/ColonandRectumCancer/DetailedGuide/colorectal-cancer-key-statistics?sitearea

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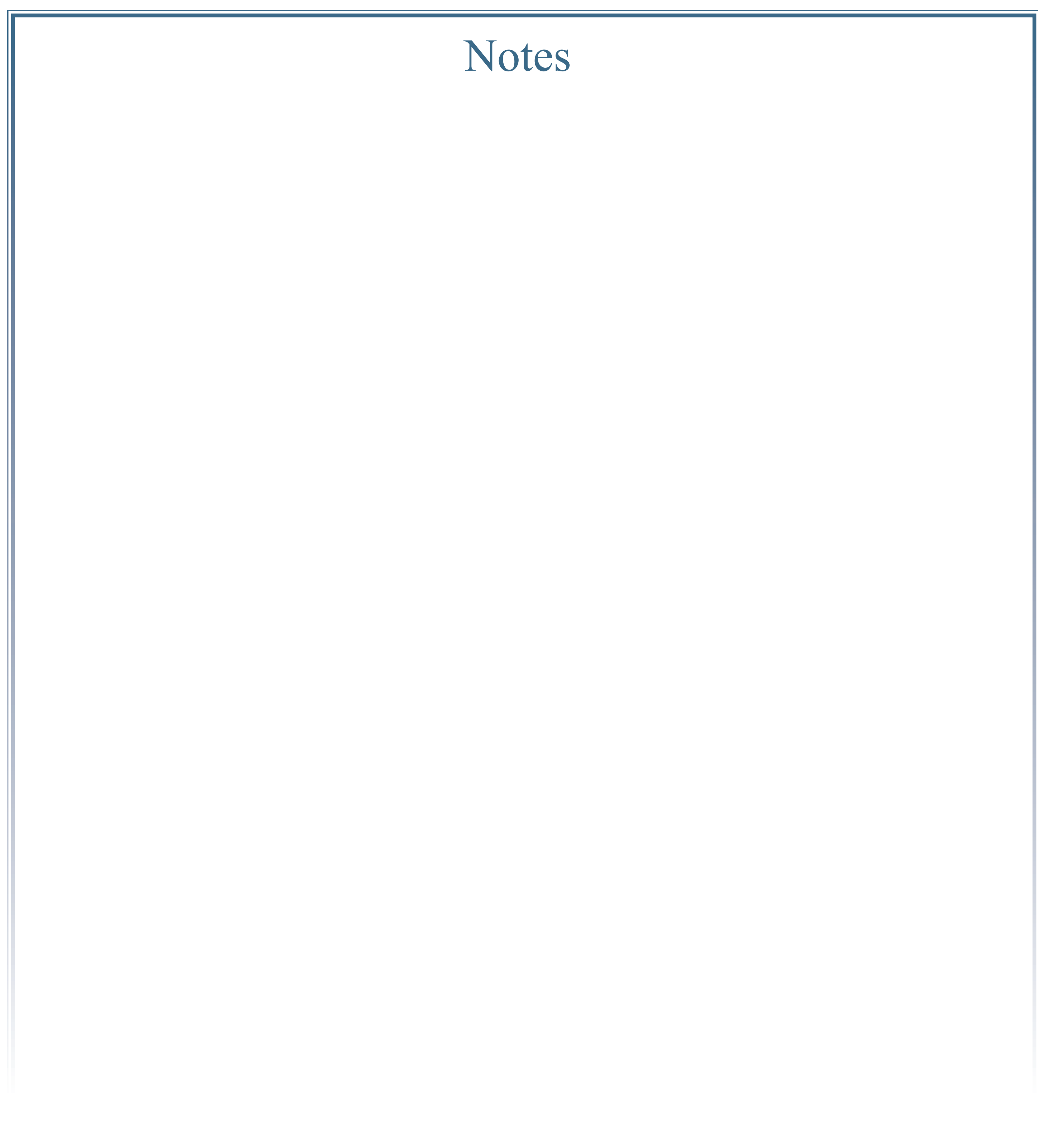
More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.



Notes

Chapter 12
Prostate Cancer Screening

Overview

Medicare provides coverage of prostate cancer screening tests/procedures for the early detection of prostate cancer. The two most common screenings used by physicians to detect prostate cancer are the screening Prostate Specific Antigen (PSA) blood test and the screening Digital Rectal Examination (DRE).

> **Removal of Barriers to Preventive Services Under the Affordable Care Act**
>
> For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.
>
> The coinsurance or copayment and deductible for the Prostate Specific Antigen (PSA) blood test are waived, although it is not graded A or B by the USPSTF. The coinsurance or copayment and deductible for the Digital Rectal Examination (DRE) are not waived. The Affordable Care Act does not affect the application of the coinsurance or copayment and deductible for either the PSA blood test or the DRE.
>
> The Affordable Care Act revised the list of preventive care services paid by Medicare in the Federally Qualified Health Center (FQHC) setting. For dates of service on or after January 1, 2011, the professional component of the PSA blood test is a covered FQHC service when provided by an FQHC. The professional component of the DRE is already an FQHC service and is not changed by the Affordable Care Act.

PSA Blood Test

Prostate specific antigen is a protein produced by the cells of the prostate gland and released into the blood. The screening PSA blood test measures the level of prostate specific antigen in an individual's blood. The Food and Drug Administration (FDA) approved the use of the PSA blood test along with a DRE to help detect prostate cancer in men aged 50 and older. The FDA also approved the PSA blood test to monitor individuals with a history of prostate cancer to determine if the cancer recurs.

PSA is a tumor marker for adenocarcinoma of the prostate that can help to predict residual tumors in the post-operative phase of prostate cancer. Three to six months following a radical prostatectomy, PSA is reported as providing a sensitive indicator of persistent disease. Six months following introduction of antiandrogen therapy, PSA is reported as capable of distinguishing individuals with favorable response from those in whom limited response is anticipated.

Once a diagnosis is established, PSA serves as a marker to follow the progress of most prostate tumors. The PSA blood test also aids in managing individuals with prostate cancer and in detecting metastatic or persistent disease following treatment. The PSA blood test helps differentiate benign from malignant disease in men with lower urinary tract symptoms (e.g., hematuria, slow urine stream, hesitancy, urgency, frequency, nocturia, and incontinence). It is also of value for men with palpably abnormal prostate glands found during physical exam and for men with other laboratory or imaging studies that suggest the possibility of a malignant prostate disorder. PSA blood testing may also be useful in the differential diagnosis of men with undiagnosed disseminated metastatic disease.

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

DRE

The screening DRE is a clinical examination for checking the health of an individual's prostate gland. The prostate is checked for size and any irregularities or abnormalities of the prostate gland.

Risk Factors

All men are at risk for prostate cancer; however, the causes of prostate cancer are not yet clearly understood. Through research, several factors have been identified that increase a beneficiary's risk. Risk factors include the following:

- Family history of prostate cancer,
- Men aged 50 and older,
- Diet of red meat and high fat dairy, and
- Smoking.

The following list gives the order of prostate cancer risk among ethnic groups from highest to lowest:

- African-Americans,
- Caucasians,
- Hispanic-Americans,
- Asian-Americans,
- Pacific Islanders, and
- Native Americans.

Other Helpful Information

The USPSTF has determined that the evidence is insufficient to recommend for or against routine screening for prostate cancer using PSA testing or DRE. Prostate cancer screening is associated with possible harms including anxiety and follow-up procedures based on frequent false-positive test results, as well as the complications that may result from treating prostate cancers that, if left untreated, might not have affected the individual's health.

Since current evidence is insufficient to determine whether the potential benefits of prostate cancer screening outweigh its potential harms, there is no scientific consensus that such screening is beneficial. The USPSTF recommends that clinicians discuss the harms and benefits of prostate cancer screening with their patients before performing screening procedures.

If early detection through screening does improve health outcomes, those most likely to benefit would be men 50 through 70 years of age who are at average risk for prostate cancer and men aged 45 and older who are at increased risk (African-American men and men whose first-degree relatives have had prostate cancer are at increased risk). Benefits may be smaller among Asian-Americans, Hispanic-Americans, and other racial and ethnic groups at lower risk for prostate cancer.

Coverage Information

Medicare provides coverage of an annual preventive prostate cancer screening PSA blood test and DRE once every 12 months for all male beneficiaries aged 50 and older (coverage begins the day after the beneficiary's 50th birthday), if at least 11 months have passed following the month in which the last Medicare-covered screening PSA blood test or DRE was performed for the early detection of prostate cancer.

Stand Alone Benefit

The prostate cancer screening benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

Calculating Frequency

When calculating frequency to determine the 11-month period, the count starts beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received a screening PSA blood test in January 2010. The count starts beginning February 2010. The beneficiary is eligible to receive another screening PSA blood test in January 2011 (the month after 11 months have passed).

Screening PSA Blood Test

The screening PSA blood test must be ordered by the beneficiary's physician or by the beneficiary's qualified non-physician practitioner who is fully knowledgeable about the beneficiary's medical condition and would be responsible for explaining the results of the test to the beneficiary.

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

Who Are Physicians and Qualified Non-Physician Practitioners?

Physician

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

Qualified Non-Physician Practitioner

For the purpose of prostate cancer screening, a qualified non-physician practitioner is a physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife.

Screening DRE

The screening DRE must be performed by a physician or qualified non-physician practitioner who is authorized under state law to perform the examination, is fully knowledgeable about the beneficiary's medical condition, and is responsible for explaining the results of the examination to the beneficiary.

Medicare provides coverage of the screening DRE as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment apply to this benefit.

NOTE: The Medicare Part B deductible does not apply to Federally Qualified Health Center (FQHC) services.

Documentation

Medical record documentation must show the annual preventive screenings were ordered for the purpose of early detection of prostate cancer and that the beneficiary is aged 50 or older.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) codes, listed in Table 1, must be used to report prostate cancer screening.

Table 1 – HCPCS Codes for Prostate Cancer Screening

HCPCS Code	Code Descriptor
G0102	Prostate cancer screening; digital rectal examination (DRE)
G0103	Prostate cancer screening; prostate specific antigen test (PSA)

IMPORTANT NOTE

When submitting claims for the annual preventive PSA blood test, bill for a screening test, which is covered once every 12 months, and not for a diagnostic test.

Diagnosis Requirements

Medicare providers must report the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening ("V") diagnosis code, listed in Table 2, for prostate cancer screening. For further guidance, contact the local Medicare Contractor.

Table 2 – Diagnosis Code for Prostate Cancer Screening

ICD-9-CM Diagnosis Code	Code Descriptor
V76.44	Special screening for malignant neoplasms, prostate

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS code (G0102 or G0103) and the corresponding ICD-9-CM diagnosis code (V76.44) in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Claims Act (ASCA) requirement, Form CMS-1500 may be used to submit those claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS codes (G0102 or G0103), the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code (V76.44) in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form

National Correct Coding Initiative (NCCI) Edits

Refer to the currently applicable bundled carrier processed procedures at http://www.cms.gov/NationalCorrectCodInitEd on the CMS website.

CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for prostate cancer screening when submitted with the following TOBs and associated revenue codes, listed in Table 3.

Table 3 – Facility Types, TOBs, and Revenue Codes for Prostate Cancer Screening

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X	0770 – DRE 030X – PSA
Hospital Outpatient	13X	0770 – DRE 030X – PSA
Hospital Non-Patient Laboratory Specimens including CAH	14X	030X – PSA
Skilled Nursing Facility (SNF) Inpatient Part B*	22X	0770 – DRE 030X – PSA
SNF Outpatient	23X	0770 – DRE 030X – PSA
Rural Health Clinic (RHC)	71X	052X – DRE only See Additional Billing Instructions for RHCs and FQHCs
Federally Qualified Health Center (FQHC)	77X	052X – DRE only 052X – PSA (for dates of service on or after January 1, 2011, only) See Additional Billing Instructions for RHCs and FQHCs
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0770 – DRE 030X – PSA
CAH Outpatient**	85X	0770 – DRE 030X – PSA

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for prostate cancer screening for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Prostate cancer screenings provided by other facility types must be reimbursed by the SNF.

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

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

For dates of service on or after July 1, 2009, a CAH will be paid 101 percent of reasonable costs for outpatient clinical diagnostic laboratory tests, and the beneficiary is no longer required to be physically present in a CAH at the time the specimen is collected. However, the beneficiary must be an outpatient of the CAH and be receiving services directly from the CAH. In order for the beneficiary to be receiving services directly from the CAH, the beneficiary must either be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or an entity that is provider-based to the CAH.

Additional Billing Instructions for RHCs and 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.

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

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

- **Technical Component** for Provider-Based RHCs and FQHCs:
  - The base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **Technical Component** for Independent RHCs and FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component for Dates of Service Prior to January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a physician or qualified non-physician practitioner furnishes a DRE within an RHC/FQHC, the service is considered an RHC/FQHC service. The provider of the DRE must bill the FI/AB MAC under TOB 71X or 77X, respectively. The professional portion of the service is billed to the FI/AB MAC using revenue code 052X.
- **Professional Component for Dates of Service on or After January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - Detailed HCPCS coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The RHC/FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment (and deductible for RHCs). An additional line with revenue code 052X should be submitted with the appropriate HCPCS code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive

encounter rate, and coinsurance or copayment and deductible will not apply.

- If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/Current Procedural Terminology (CPT) code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.
- Although most preventive services have HCPCS/CPT codes that allow separate billing of professional and technical components, prostate cancer screening services do not. However, RHCs/FQHCs still may provide the professional component of these services since they are in the scope of the RHC/FQHC benefit. Such encounters are billed on line items using revenue code 052X.

Reimbursement Information

General Information

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

Medicare provides coverage of the screening DRE as a Medicare Part B benefit. The Medicare Part B deductible and the coinsurance or copayment apply to this benefit.

NOTE: The Medicare Part B deductible does not apply to FQHC services.

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses the screening PSA blood test (HCPCS code G0103) under the Clinical Laboratory Fee Schedule. Payment for the service is never bundled.

Medicare reimburses the screening DRE (HCPCS code G0102) under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all prostate cancer screenings.

Payment for the screening DRE is bundled into payment for a covered Evaluation and Management (E/M) service (CPT codes 99201-99456 and 99499), when the two services are furnished to a beneficiary on the same day. If the screening 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.

Clinical Laboratory Fee Schedule Information

For more information about the Clinical Laboratory Fee Schedule, visit http://www.cms.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Medicare Physician Fee Schedule (MPFS) Information

For more information about the MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

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Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for screening PSA blood tests (HCPCS code G0103) is made under the Clinical Laboratory Fee Schedule for all TOBs, except for some CAH services (and FQHC services for dates of service on or after January 1, 2011, only).

NOTE: For dates of service on or after July 1, 2009, a CAH will be paid 101 percent of reasonable costs for outpatient clinical diagnostic laboratory tests, and the beneficiary is no longer required to be physically present in a CAH at the time the specimen is collected. However, the beneficiary must be an outpatient of the CAH and be receiving services directly from the CAH. In order for the beneficiary to be receiving services directly from the CAH, the beneficiary must either be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or an entity that is provider-based to the CAH.

Medicare makes payment for screening DREs (HCPCS code G0102) under the payment methods listed in Table 4 for the following TOBs. (These screening services are not bundled when billed to FIs/AB MACs.)

Table 4 – TOBs and Payment Methodology for Screening DREs

Type of Bill	Basis of Payment
12X, 13X, 14X*	Outpatient Prospective Payment System (OPPS)
22X**, 23X, 75X	Medicare Physician Fee Schedule (MPFS)
71X***, 77X	All-Inclusive Encounter Rate
85X	Cost (Payment should be consistent with amounts paid for Current Procedural Terminology [CPT] code 84153 or CPT code 86316)

***NOTE:** TOB 14X is for non-patient laboratory specimens only.

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for prostate cancer screening for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Prostate cancer screenings provided by other facility types must be reimbursed by the SNF.

*****NOTE:** Payment for the screening DRE is included in the all-inclusive encounter rate. RHCs should include the charges on the claims for future inclusion in encounter rate calculations.

Outpatient Prospective Payment System (OPPS) Information

For more information about OPPS, visit http://www.cms.gov/HospitalOutpatientPPS on the CMS website.

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Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of the prostate cancer screening services:

- The beneficiary is not at least aged 50 and older (coverage begins the day after the beneficiary's 50th birthday).
- The beneficiary has received a covered PSA/DRE during the past year.
- The beneficiary received a covered E/M service on the same day as the DRE from the physician (carrier/AB MAC only).

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Prostate Cancer Screening

Resources

Centers for Disease Control and Prevention (CDC) Prostate Cancer Information
http://www.cdc.gov/cancer/prostate

CMS Prostate Cancer Screening Web Page
http://www.cms.gov/ProstateCancerScreening

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 50
http://www.cms.gov/manuals/downloads/clm104c18.pdf

Medicare Learning Network® (MLN) "Cancer Screenings" Brochure (ICN 006434)
http://www.cms.gov/MLNProducts/downloads/Cancer_Screening.pdf

"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.1
http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

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

National Cancer Institute Prostate Cancer Information
http://www.cancer.gov/cancertopics/types/prostate

Prostate Cancer Screening: A Decision Guide
An informational guide prepared by the CDC
http://www.cdc.gov/cancer/prostate/informed_decision_making.htm

The PSA Test: Questions and Answers
A Frequently Asked Questions document prepared by the Cancer Information Service, a program of the National Cancer Institute
http://www.cancer.gov/cancertopics/factsheet/Detection/PSA

USPSTF Recommendations
This website provides the USPSTF written recommendations on screening for prostate cancer.
http://www.uspreventiveservicestaskforce.org/uspstf/uspsprca.htm

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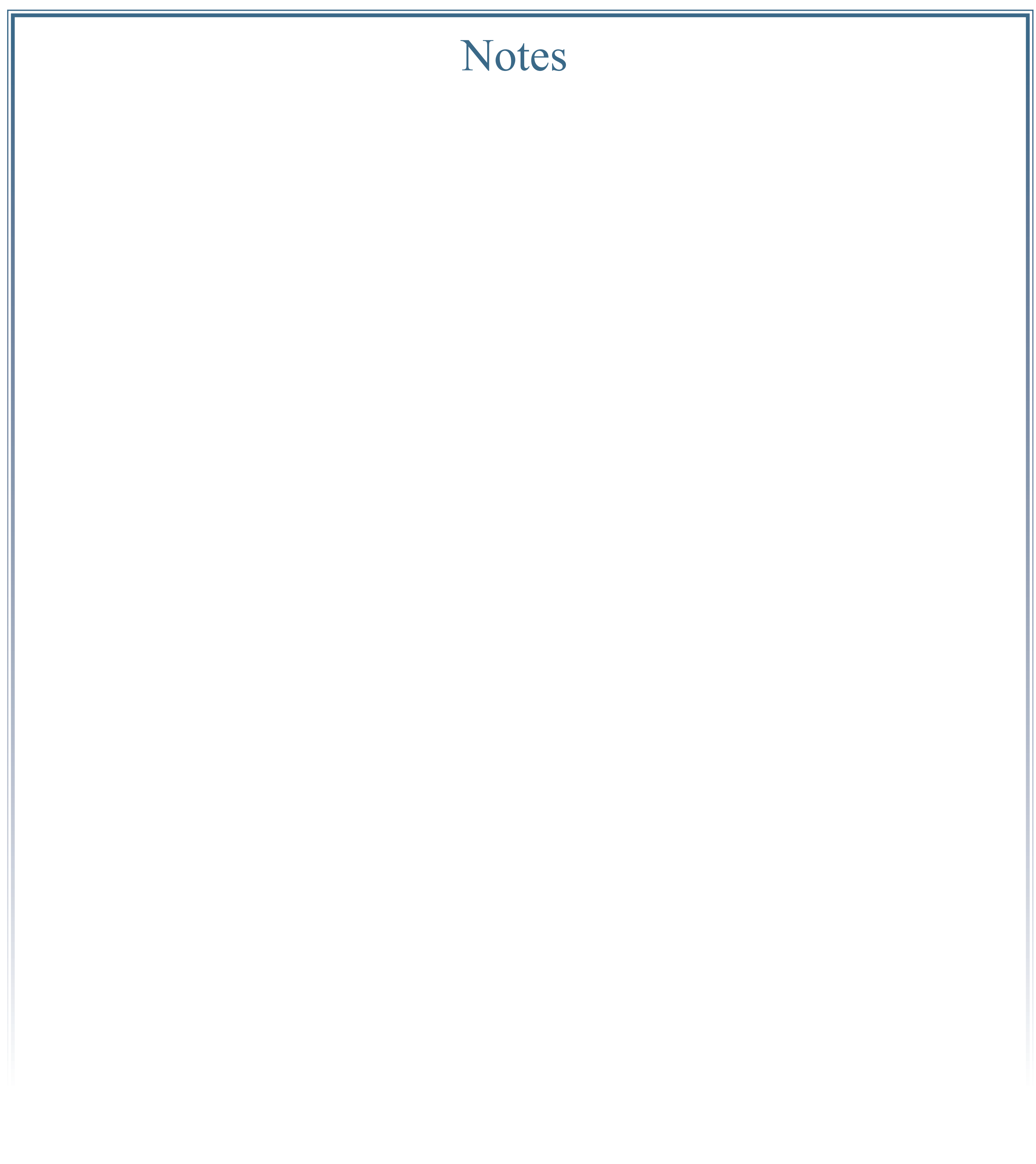
More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes

Notes



Chapter 13
Human Immunodeficiency Virus Screening

Overview

Acquired Immunodeficiency Syndrome (AIDS) is diagnosed when an individual infected with the Human Immunodeficiency Virus (HIV) becomes severely compromised and/or a person becomes ill with an HIV-related opportunistic infection. Without treatment, AIDS usually develops within 8-10 years after a person's initial HIV infection. While there is presently no cure for HIV, an infected individual can be recognized by screening, and subsequent access to skilled care plus vigilant monitoring and adherence to treatment may delay the onset of AIDS and increase the quality of life for many years.

Significantly, more than half of new HIV infections are estimated to be sexually transmitted from infected individuals who are unaware of their HIV status. Consequently, wider availability of screening linked to HIV care and treatment could decrease the spread of disease to those living with or partnered with HIV-infected individuals.

HIV infection disproportionately impacts identifiable racial, gender, and ethnic groups, and thus requires sensitivity to cultural and linguistic barriers to screening and access to medical care. By transmission category, men who have sex with men remain the most affected group in the United States, accounting for about half of Americans living with HIV. Most HIV infections in American women are heterosexually acquired, including a 4.1 percent increase per year between 1999 and 2004 among women aged 60 and older.

Medicare coverage of HIV screening began for dates of service on or after December 8, 2009.

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

The coinsurance or copayment and deductible for Human Immunodeficiency Virus (HIV) screening were already waived and are not affected by the Affordable Care Act.

The Affordable Care Act revised the list of preventive care services paid by Medicare in the Federally Qualified Health Center (FQHC) setting. For dates of service on or after January 1, 2011, the professional component of HIV screening is a covered FQHC service when provided by an FQHC.

HIV Screening

Diagnosis of HIV infection is primarily made through the use of serologic assays. These assays take one of two forms: antibody detection assays and specific HIV antigen (p24) procedures. The antibody assays are usually enzyme immunoassays (EIA), which are used to confirm exposure of an individual's immune system to specific viral antigens. These assays may be formatted to detect HIV-1, HIV-2, or HIV-1 and 2 simultaneously, and to detect both Immunoglobulin M (IgM) and Immunoglobulin G (IgG). When the initial EIA test is repeatedly positive or indeterminate, an alternative test is used to confirm the specificity of the antibodies to individual viral components. The most commonly used method is the Western Blot.

The HIV-1 core antigen (p24) test detects circulating viral antigen, which may be found prior to the development of antibodies and may be present in later stages of illness in the form of recurrent or persistent antigenemia. Its prognostic utility in HIV infection has been diminished as a result of development of sensitive viral ribonucleic acid (RNA) assays, and its primary use today is as a routine screening tool in potential blood donors.

In several unique situations, serologic testing alone may not reliably establish an HIV infection. This may occur because the antibody response (particularly the IgG response detected by Western Blot) has not yet developed (that is, acute retroviral syndrome) or is persistently equivocal because of inherent viral antigen variability. It is also an issue in perinatal HIV infection due to transplacental passage of maternal HIV antibody. In these situations, laboratory evidence of HIV in blood by culture, antigen assays, or proviral deoxyribonucleic acid (DNA) or viral RNA assays is required to establish a definitive determination of HIV infection.

Risk Factors

While anyone can contract HIV, the USPSTF has identified eight increased-risk criteria:

1. Men who have had sex with men after 1975;
2. Men and women having unprotected sex with multiple (more than one) partners;
3. Past or present injection drug users;
4. Men and women who exchange sex for money or drugs or who have sex partners who do;
5. Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users;
6. Individuals being treated for sexually transmitted diseases;
7. Individuals with a history of blood transfusion between 1978 and 1985; and
8. Individuals who request an HIV test despite reporting no individual risk factors, since this group is likely to include individuals not willing to disclose high-risk behaviors.

Coverage Information

Medicare provides coverage of both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests as follows:

- A maximum of once annually for beneficiaries at increased risk for HIV infection (11 full months must elapse following the month the previous test was performed in order for the subsequent test to be covered); and
- A maximum of three times per term of pregnancy for pregnant Medicare beneficiaries beginning with the date of the first test when ordered by the woman’s clinician, at the following times:
  - When the diagnosis of pregnancy is known;
  - During the third trimester; and
  - At labor, if ordered by the woman’s physician.

NOTE: Beneficiaries with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

Indications

Diagnostic testing to establish HIV infection may be indicated when there is a strong clinical suspicion supported by one or more of the following clinical findings:

1. The beneficiary has a documented, otherwise unexplained, AIDS-defining or AIDS-associated opportunistic infection.
2. The beneficiary has another documented sexually transmitted disease, which identifies significant risk of exposure to HIV and the potential for an early or subclinical infection.
3. The beneficiary has documented acute or chronic hepatitis B or C infection that identifies a significant risk of exposure to HIV and the potential for an early or subclinical infection.
4. The beneficiary has a documented AIDS-defining or AIDS-associated neoplasm.
5. The beneficiary has a documented AIDS-associated neurologic disorder or otherwise unexplained dementia.
6. The beneficiary has another documented AIDS-defining clinical condition, or a history of other severe, recurrent, or persistent conditions which suggest an underlying immune deficiency (e.g., cutaneous or mucosal disorders).
7. The beneficiary has otherwise unexplained generalized signs and symptoms suggestive of a chronic process with an underlying immune deficiency (e.g., fever, weight loss, malaise, fatigue, chronic diarrhea, failure to thrive, chronic cough, hemoptysis, shortness of breath, or lymphadenopathy).
8. The beneficiary has otherwise unexplained laboratory evidence of a chronic disease process with an underlying immune deficiency (e.g., anemia, leukopenia, pancytopenia, lymphopenia, or low CD4+ lymphocyte count).
9. The beneficiary has signs and symptoms of acute retroviral syndrome with fever, malaise, lymphadenopathy, and skin rash.
10. The beneficiary has documented exposure to blood or body fluids known to be capable of transmitting HIV (e.g., needle sticks and other significant blood exposures) and antiviral therapy is initiated or anticipated to be initiated.
11. The beneficiary is undergoing treatment for rape. (HIV testing is part of the rape treatment protocol.)

Limitations

1. HIV antibody testing in the United States is usually performed using HIV-1 or HIV-1/2 combination tests. HIV-2 testing is indicated if clinical circumstances suggest HIV-2 is likely (that is, compatible clinical finding and HIV-1 test negative). HIV-2 testing may also be indicated in areas of the country where there is greater prevalence of HIV-2 infections.
2. The Western Blot test should be performed only after documentation that the initial EIA tests are repeatedly positive or equivocal on a single sample.
3. The HIV antigen tests currently have no defined diagnostic usage.
4. Direct viral RNA detection may be performed in those situations where serologic testing does not establish a diagnosis but strong clinical suspicion persists (e.g., acute retroviral syndrome, nonspecific serologic evidence of HIV, or perinatal HIV infection).
5. If initial serologic tests confirm an HIV infection, repeat testing is not indicated.
6. If initial serologic tests are HIV EIA negative and there is no indication for confirmation of infection by viral RNA detection, the interval prior to retesting is three to six months.
7. Testing for evidence of HIV infection using serologic methods may be medically appropriate in situations where there is a risk of exposure to HIV.

8. The Current Procedural Terminology (CPT) Editorial Panel has issued a number of codes for infectious agent detection by direct antigen or nucleic acid probe techniques that have not yet been developed or are only being used on an investigational basis. Laboratory providers are advised to remain current on FDA-approved status for these tests.

Coinsurance or Copayment and Deductible

Medicare provides coverage for HIV screening as a Medicare Part B benefit. The beneficiary will pay nothing (there is no coinsurance or copayment or Medicare Part B deductible for this benefit).

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding Systems (HCPCS) codes, listed in Table 1, must be used to report HIV screening.

Table 1 – HCPCS Codes for HIV Screening*

HCPCS Code	Code Descriptor
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 or HIV-2, screening
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening

***NOTE:** Between December 8, 2009, and April 4, 2010, these services can be billed with unlisted CPT code 87999. Between April 5, 2010, and January 1, 2011, the G-codes will be contractor priced. For dates of service on or after January 1, 2011, payment for HIV screening is under the Medicare Clinical Laboratory Fee Schedule for Types of Bill (TOBs) 12X, 13X, 14X, 22X, and 23X. For TOB 85X, payment is based on reasonable cost.

Diagnosis Requirements

Medicare providers must report the appropriate International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening (“V”) diagnosis code(s), listed in Tables 2, 3, and 4, for HIV screening.

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Table 2 – Diagnosis Codes for HIV Screening for Beneficiaries Reporting Increased Risk Factors

ICD-9-CM Diagnosis Code	Primary or Secondary Diagnosis	Code Descriptor
V73.89	Primary	Special screening for other specified viral disease
V69.8	Secondary	Other problems related to lifestyle

Table 3 – Diagnosis Code for HIV Screening for Beneficiaries Not Reporting Increased Risk Factors

ICD-9-CM Diagnosis Code	Primary or Secondary Diagnosis	Code Descriptor
V73.89	Primary	Special screening for other specified viral disease

Table 4 – Diagnosis Codes for HIV Screening for Pregnant Beneficiaries

ICD-9-CM Diagnosis Code	Primary or Secondary Diagnosis	Code Descriptor
V73.89	Primary	Special screening for other specified viral disease
V22.0	Secondary	Supervision of normal first pregnancy
V22.1	Secondary	Supervision of other normal pregnancy
V23.9	Secondary	Supervision of unspecified high-risk pregnancy

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS code and the corresponding ICD-9-CM diagnosis code(s) in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs for HIV screening, Medicare providers must report the appropriate HCPCS code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code(s) in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for the HIV screening benefit when submitted on the following TOBs and associated revenue codes, listed in Table 5.

Table 5 – Facility Types, TOBs, and Revenue Codes for HIV Screening

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X	030X
Hospital Outpatient	13X	030X
Hospital Non-Patient Laboratory Specimens	14X	030X
Skilled Nursing Facility (SNF) Inpatient Part B*	22X	030X
SNF Outpatient	23X	030X
CAH**	85X	030X
Indian Health Service (IHS) Provider	13X	030X
IHS Inpatient Part B including CAH	12X	030X
IHS CAH	85X	030X

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for HIV screening for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. HIV screening provided by other facility types must be reimbursed by the SNF.

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

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

For dates of service on or after July 1, 2009, a CAH will be paid 101 percent of reasonable costs for outpatient clinical diagnostic laboratory tests, and the beneficiary is no longer required to be physically present in a CAH at the time the specimen is collected. However, the beneficiary must be an outpatient of the CAH and be receiving services directly from the CAH. In order for the beneficiary to be receiving services directly from the CAH, the beneficiary must either be receiving

outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or an entity that is provider-based to the CAH.

Additional Billing Instructions for RHCs

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

Additional Billing Instructions for Federally Qualified Health Centers (FQHCs)

Dates of Service Prior to January 1, 2011

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

Dates of Service on or After January 1, 2011

The Affordable Care Act revised the list of preventive services paid by Medicare in the FQHC setting. For dates of service on or after January 1, 2011, the professional component of HIV screening is a covered FQHC service when provided by an FQHC. FQHCs should follow these billing instructions to ensure that proper payment is made for services and to allow the Common Working File (CWF) to perform age and frequency editing.

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

- **Technical Component** for Provider-Based FQHCs:
    - The base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **Technical Component** for Independent FQHCs:
    - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component** for Provider-Based FQHCs and Freestanding FQHCs:
    - Detailed HCPCS coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment. An additional line with revenue code 052X should be submitted with the appropriate HCPCS code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive encounter rate, and coinsurance or copayment and deductible will not apply.

- ○ If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/CPT code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.

Reimbursement Information

General Information

Medicare provides coverage for HIV screening as a Medicare Part B benefit. The beneficiary will pay nothing (there is no coinsurance or copayment or Medicare Part B deductible for this benefit).

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses HIV screening under the Clinical Laboratory Fee Schedule.

Clinical Laboratory Fee Schedule

For more information about the Clinical Laboratory Fee Schedule, visit http://www.cms.gov/ClinicalLabFeeSched on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for HIV screening depends on the type of facility providing the service. Table 6 lists the type of payment that facilities receive for HIV screening.

Table 6 – Facility Payment Methodology for HIV Screening*

Facility Type	Basis of Payment
Hospital	Clinical Laboratory Fee Schedule
Skilled Nursing Facility (SNF)**	Clinical Laboratory Fee Schedule
Federally Qualified Health Center (FQHC) for dates of service on or after January 1, 2011	All-Inclusive Encounter Rate
Critical Access Hospital (CAH)	Reasonable Cost
Indian Health Service (IHS) Provider	Clinical Laboratory Fee Schedule
IHS CAH	Reasonable Cost

***NOTE:** Between December 8, 2009, and April 4, 2010, these services can be billed with unlisted CPT code 87999. Between April 5, 2010, and January 1, 2011, the G-codes will be contractor priced. For dates of service on or after January 1, 2011, payment for HIV screening is under the Medicare Clinical Laboratory Fee Schedule for TOBs 12X, 13X, 14X, 22X, and 23X. For TOB 85X, payment is based on reasonable cost.

****NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for HIV screening for beneficiaries in a skilled Part A SNF stay; however, the SNF must submit these services on a 22X TOB. HIV screening provided by other facility types must be reimbursed by the SNF.

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Reasons for Claim Denial

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

- The beneficiary received an HIV screening within the past year (not because of pregnancy).
- The beneficiary received three HIV screenings within the current pregnancy.

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

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Human Immunodeficiency Virus Screening

Resources

AIDS.gov
http://aids.gov

AIDSInfo.gov
http://www.aidsinfo.nih.gov

Centers for Disease Control and Prevention (CDC) HIV Website
http://www.cdc.gov/hiv

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 130
http://www.cms.gov/manuals/downloads/clm104c18.pdf

Medicare Learning Network (MLN) Matters® Article MM6786 (Revised), "Screening for the Human Immunodeficiency Virus (HIV) Infection"
http://www.cms.gov/MLNMattersArticles/downloads/MM6786.pdf

"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 3, Sections 190.13 and 190.14
http://www.cms.gov/manuals/downloads/ncd103c1_Part3.pdf

"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.7
http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

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

USPSTF Recommendations
This website provides the USPSTF written recommendations on screening for HIV.
http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm

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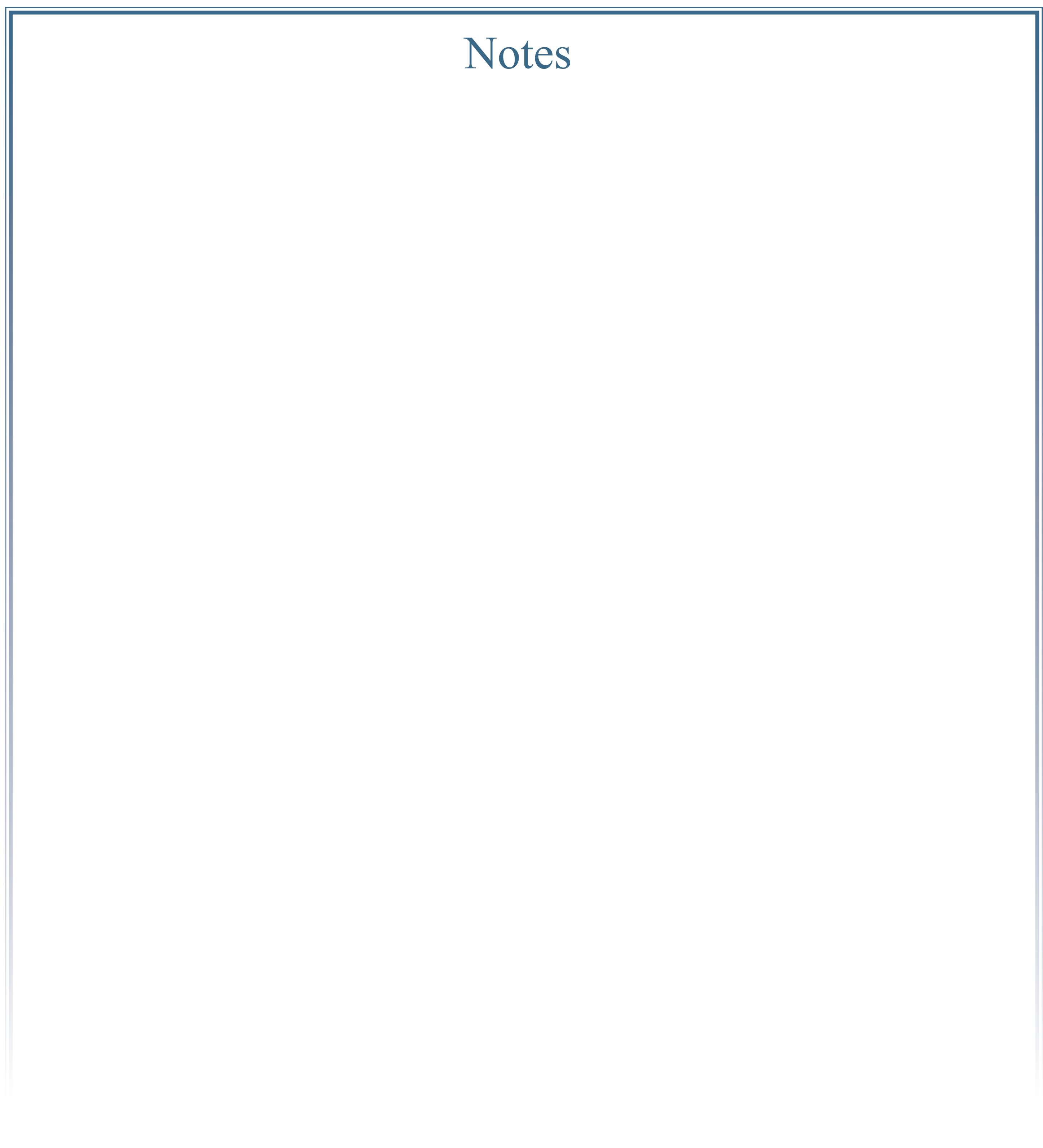
More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes


Notes

Chapter 14
Bone Mass Measurements

Overview

Osteoporosis, or "porous bone," is a disease of the skeletal system characterized by low bone mass and deterioration of bone tissue. Osteoporosis produces an enlargement of the pore spaces in the bone, causing increased fragility and an increased risk for fracture, typically in the wrist, hip, and spine. An estimated 10 million Americans have osteoporosis and more than 34 million Americans have low bone mass, placing them at increased risk for osteoporosis. One out of every 2 women and 1 in 4 men aged 50 and older will have an osteoporosis-related fracture in their lifetime. The good news is osteoporosis is a preventable and treatable disease. Early diagnosis and treatment can reduce or prevent fractures. Medicare's bone mass measurement benefit can aid in the early detection of osteoporosis before fractures happen, provide a precursor to future fractures, and determine rate of bone loss.

Medicare's bone mass measurement benefit includes a physician's interpretation of the procedure's results.

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

The coinsurance or copayment and deductible apply for the bone mass measurement benefit. For dates of service on or after January 1, 2011, both are waived by the Affordable Care Act.

Bone Mass Measurement Defined

"Bone mass measurement," also known as "bone density study," is a radiological or radioisotope procedure or other procedure approved by the Food and Drug Administration (FDA). It identifies bone mass, detects bone loss, or determines bone quality. Bone mass measurements evaluate bone diseases and/or responses to treatment; they include a physician's interpretation of the procedure's results. The studies assess bone mass or density associated with osteoporosis and other bone abnormalities.

Methods of Bone Mass Measurements

Bone density is usually studied using diagnostic bone mass measurement techniques recognized by the FDA. Bone density can be measured at the wrist, spine, hip, or calcaneus (heel). Single and combined measurements may be required to diagnose bone disease, monitor bone changes with disease progression, or monitor bone changes with therapy.

Medicare provides coverage for the following densitometers:

- A **stationary** device permanently located in an office,
- A **mobile** device transported by vehicle from site to site, and
- A **portable** device picked up and moved from one site to another.

To ensure accurate measurement and consistent test results, bone density studies for periodic follow-up tests should generally 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.

Risk Factors

Osteoporosis can develop in anyone; however, some risk factors for developing osteoporosis include the following:

- Aged 50 and older,
- Female gender,
- Family history of broken bones,
- Personal history of broken bones,
- Caucasian or Asian-American ethnicity,
- Small bone structure,
- Low body weight (less than 127 pounds),
- Frequent smoking or drinking, and
- Low-calcium diet.

Important Note

Although risk factors may put some individuals at increased risk for developing osteoporosis, Medicare does not provide coverage of bone mass measurement for all beneficiaries in these high risk groups. Medicare provides coverage for bone mass measurements for qualified beneficiaries when all of the benefit coverage criteria described in the Coverage Information section are met.

Coverage Information

Medicare provides coverage of bone mass measurements that meet coverage criteria 1-6 below.

1. The bone mass measurement is performed on a qualified individual. A “qualified individual” means a Medicare beneficiary who meets the medical indications for at least one of the following categories:
   - 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, demonstrated by an X-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture;
   - An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone or greater per day for more than three months;
   - An individual with known primary hyperparathyroidism; or
   - An individual being monitored to assess the response to, or efficacy of, an FDA-approved osteoporosis drug therapy.
2. The physician or qualified non-physician practitioner treating the qualified individual must provide an order for a bone mass measurement test, following an evaluation of the need for a bone mass measurement that included a determination of the medically appropriate measurement 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 beneficiary.

Who Are Physicians and Qualified Non-Physician Practitioners?

Physician

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

Qualified Non-Physician Practitioner

For the purpose of bone mass measurement, a qualified non-physician practitioner is a physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife.

Stand Alone Benefit

The bone mass measurement benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following a beneficiary’s Medicare Part B enrollment.

3. The service must be a radiologic or radioisotopic procedure (or other procedure) that meets the following requirements:
   - Is performed with a bone densitometer (other than dual photon absorptiometry) or a bone sonometer (e.g., ultrasound) device approved or cleared for marketing by the FDA;
   - Is performed for the purpose of identifying bone mass, detecting bone loss, or determining bone quality; and
   - Includes a physician's interpretation of the procedure's results.
4. A qualified supplier or provider must furnish such services under the appropriate level of supervision by a physician.
5. The service must be reasonable and medically necessary to diagnose, treat, or monitor a qualified individual.
6. The service must be performed at a frequency that conforms to the requirements below.

Frequency Requirements

Medicare provides coverage of a bone mass measurement that meets the criteria described above once every 2 years (i.e., at least 23 months after the last covered bone mass measurement test was performed).

NOTE: If medically necessary, Medicare may provide coverage for a beneficiary more frequently than every two years. (See the text box on the right for examples of situations in which Medicare may provide more frequent coverage of bone mass measurements.)

Examples of More Frequent Coverage

Examples of situations in which more frequent bone mass measurements may be medically necessary include, but are not limited to, the following medical conditions:

- Monitoring patients on long-term glucocorticoid (steroid) therapy for more than three months.
- Allowing for a confirmatory baseline bone density study to permit monitoring in the future if certain specified requirements are met.

Calculating Frequency

When calculating frequency to determine the 23-month period, the count starts beginning with the month after the month in which a previous procedure was performed.

EXAMPLE: The beneficiary received a bone mass measurement in January 2009. The count starts February 2009. The beneficiary is eligible to receive another bone mass measurement in January 2011 (the month after 23 months have passed).

Coinsurance or Copayment and Deductible

Medicare provides coverage of bone mass measurements as a Medicare Part B benefit. For dates of service prior to January 1, 2011, the coinsurance or copayment and Medicare Part B deductible apply to this benefit. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

NOTE: The Medicare Part B deductible does not apply to Federally Qualified Health Center (FQHC) services.

Documentation

Medical record documentation, maintained by the treating physician, must show the medical necessity for ordering bone mass measurements. The documentation may be included in any of the following:

- Beneficiary history and physical,
- Office notes,
- Test results with written interpretation, or
- X-ray/radiology with written interpretation.

NOTE: Since not every woman who has been prescribed Estrogen Replacement Therapy (ERT) may be receiving an "adequate" dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating non-physician practitioner from ordering a bone mass measurement for her. However, if a bone mass measurement is ordered for a woman following a careful evaluation of her medical need, the ordering treating physician (or other treating qualified non-physician practitioner) should document in the beneficiary's medical record the reason he or she believes that the beneficiary is estrogen-deficient and at clinical risk for osteoporosis.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Bone mass measurements are performed to establish the diagnosis of osteoporosis and to assess the individual's risk for subsequent fracture. Bone densitometry includes the use of Single Energy X-ray Absorptiometry (SEXA), Dual Energy X-ray Absorptiometry (DEXA), Quantitative Computed Tomography (QCT), and Bone Ultrasound Densitometry (BUD).

The following Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes, listed in Table 1, must be used to report bone mass measurements.

Table 1 – HCPCS/CPT Codes for Bone Mass Measurements

HCPCS/CPT Code	Code Descriptor
G0130	Single energy x-ray absorptiometry (SEXA) bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)
77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77080	Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

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HCPCS/CPT Code	Code Descriptor
77081	Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77083	Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method

NOTE: The following bone mass measurement CPT codes are not covered under Medicare, because they are not considered reasonable and necessary. (See Section 1862(a)(1)(A) of the Social Security Act [SSA]):

- 78350 – Single Photon Absorptiometry, and
- 78351 – Dual Photon Absorptiometry.

NOTE: Monitoring and confirmatory baseline bone mass measurements must be performed with a DEXA (axial) test as required by Section 1862(a)(1)(A) of the SSA.

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).

Diagnosis Requirements

Certain bone mass measurement tests are covered when used to screen beneficiaries for osteoporosis, subject to the two-year frequency standards. (Refer to the "Medicare Benefit Policy Manual," Publication 100-02, Chapter 15, Section 80.5.5 at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the Centers for Medicare & Medicaid Services [CMS] website.)

Screening Tests

Medicare providers must report the appropriate International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code, described in Table 2, for bone mass measurement screening tests.

Table 2 – Diagnosis Code for Bone Mass Measurement Screening Tests

HCPCS/CPT Code	Valid ICD-9-CM Diagnosis Code
77078, 77079, 77080, 77081, 77083, 76977, or G0130	Report a valid ICD-9-CM diagnosis code, obtained from the Medicare Contractor's list of diagnosis codes for the screening benefit's categories, which indicates the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy. Medicare Contractors will maintain a local list of valid codes for the benefit's screening categories.

NOTE: Medicare will **not** pay for claims for screening tests when the claim contains:

- HCPCS/CPT codes 77078, 77079, 77081, 77083, 76977, or G0130; but
- Does **not** contain a valid ICD-9-CM diagnosis code obtained from the Medicare Contractor's list of valid ICD-9-CM diagnosis codes indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.

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Monitoring Tests

Medicare covers DEXA (axial) tests when the tests are used to monitor FDA-approved osteoporosis drug therapy, subject to the two-year frequency standards. (Refer to the "Medicare Benefit Policy Manual," Publication 100-02, Chapter 15, Section 80.5.5 at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website.)

Medicare providers must report the appropriate ICD-9-CM diagnosis code, described in Table 3, for bone mass measurement monitoring tests.

Table 3 – Diagnosis Code for Bone Mass Measurement Monitoring Tests

CPT Code	Valid ICD-9-CM Diagnosis Code
77080	733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0

NOTE: Medicare will **not** pay for claims for monitoring tests when the claim contains:

- HCPCS/CPT codes 77078, 77079, 77081, 77083, 76977, or G0130 and ICD-9-CM diagnosis codes 733.00, 733.01, 733.02, 733.03, 733.90, or 255.0; but
- Does **not** contain a valid ICD-9-CM diagnosis code obtained from the Medicare Contractor's list of valid ICD-9-CM diagnosis codes indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT code(s) and the corresponding ICD-9-CM diagnosis code(s) in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT codes, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for bone mass measurement services when submitted on the following TOBs and associated revenue codes, listed in Table 4.

Table 4 – Facility Types, TOBs, and Revenue Codes for Bone Mass Measurements

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X	0320
Hospital Outpatient	13X	0320
Skilled Nursing Facility (SNF) Inpatient Part B*	22X	0320
SNF Outpatient	23X	0320
Rural Health Clinic (RHC)	71X	052X See Additional Billing Instructions for RHCs and FQHCs
Federally Qualified Health Center (FQHC)	77X	052X See Additional Billing Instructions for RHCs and FQHCs
CAH Outpatient**	85X	0320

***NOTE:** The SNF consolidated billing provision allows separate Medicare Part B payment for bone mass measurements for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Bone mass measurements provided by other facility types must be reimbursed by the SNF.

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

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

Additional Billing Instructions for RHCs and 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.

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

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

- **Technical Component** for Provider-Based RHCs and FQHCs:
  - The base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **Technical Component** for Independent RHCs and FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component for Dates of Service Prior to January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a physician or qualified non-physician practitioner furnishes a bone mass measurement within an RHC/FQHC, the service is considered an RHC/FQHC service. The provider of the service must bill the FI/AB MAC under TOB 71X or 77X, respectively. The professional portion of the service is billed to the FI/AB MAC using revenue code 052X.
- **Professional Component for Dates of Service on or After January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - Detailed HCPCS coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The RHC/FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment (and deductible for RHCs). An additional line with revenue code 052X should be submitted with the appropriate HCPCS code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive encounter rate, and coinsurance or copayment and deductible will not apply.
  - If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/CPT code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.

Reimbursement Information

General Information

Medicare provides coverage of bone mass measurements as a Medicare Part B benefit. For dates of service prior to January 1, 2011, the coinsurance or copayment and Medicare Part B deductible apply to this benefit. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

NOTE: The Medicare Part B deductible does not apply to FQHC services.

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses the bone mass measurements under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all bone mass measurements.

> **Medicare Physician Fee Schedule (MPFS) Information**
>
> For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for bone mass measurements depends on the current payment methodologies for radiology services and the type of facility providing the service.

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of bone mass measurements:

- The appropriate physician or qualified non-physician practitioner did not order the tests. (A physician or qualified non-physician practitioner treating the beneficiary for the purpose of the bone mass measurements 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 beneficiary.)
- The beneficiary does not meet the criteria of a qualified individual.

> **Medicare Contractor Contact Information**
>
> Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

> **Remittance Advice (RA) Information**
>
> For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Bone Mass Measurements

Resources

CMS Bone Mass Measurement Web Page
http://www.cms.gov/BoneMassMeasurement

Local Coverage Determinations (LCDs)
http://www.cms.gov/DeterminationProcess/04_LCDs.asp

"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 80.5
http://www.cms.gov/manuals/Downloads/bp102c15.pdf

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 13, Section 140
http://www.cms.gov/manuals/downloads/clm104c13.pdf

Medicare Learning Network® (MLN) "Bone Mass Measurements" Brochure (ICN 006437)
http://www.cms.gov/MLNProducts/downloads/Bone_Mass.pdf

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

National Institutes of Health (NIH) Osteoporosis and Related Bone Diseases National Resource Center
This is a website provided by the National Institute of Arthritis and Musculoskeletal and Skin Diseases.
http://www.niams.nih.gov/Health_Info/Bone

National Osteoporosis Foundation
http://www.nof.org

USPSTF Recommendations
This website provides the USPSTF written recommendations for osteoporosis screening.
http://www.uspreventiveservicestaskforce.org/uspstf/uspsoste.htm

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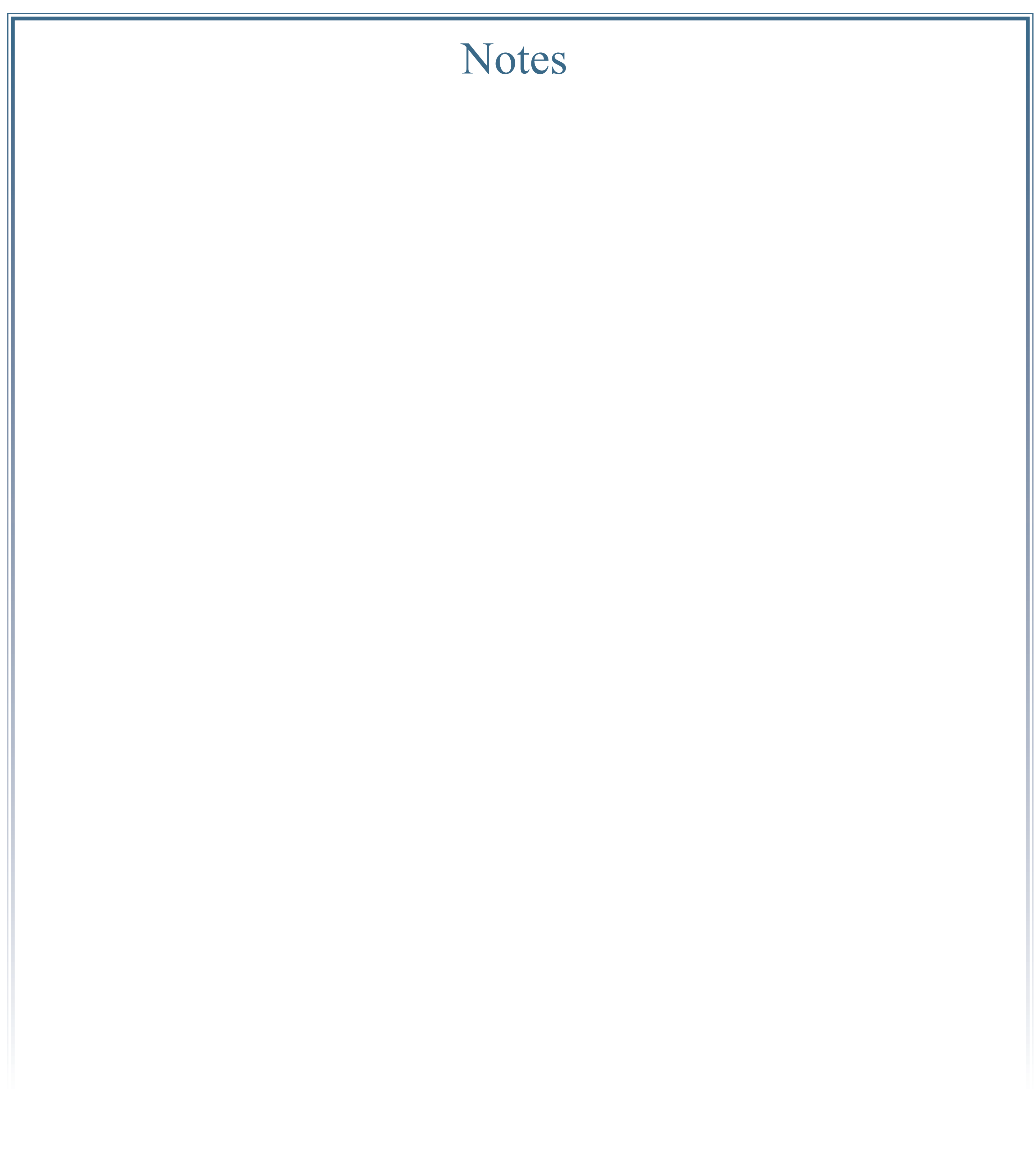
More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes



Notes

Chapter 15
Tobacco-Use Cessation Counseling Services

Overview

Tobacco use continues to be the leading cause of preventable disease and death in the United States. Smoking can contribute to and worsen heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysms, and cataracts. Smoking harms nearly every organ of the body and generally diminishes the health of smokers.

Quitting tobacco use can be difficult. Most smokers are dependent on nicotine, the psychoactive drug in tobacco products that produces dependence. Nicotine dependence is the most common form of chemical dependence in the United States. Research suggests that nicotine is as addictive as heroin, cocaine, or alcohol. Attempts to quit may be accompanied by symptoms of withdrawal, including irritability, anxiety, difficulty concentrating, and increased appetite. Tobacco dependence is a chronic condition that often requires repeated intervention.

Removal of Barriers to Preventive Services Under the Affordable Care Act

For dates of service on or after January 1, 2011, Section 4104 of the Affordable Care Act waives the coinsurance or copayment and deductible for many preventive services, including the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and certain Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible for asymptomatic beneficiaries receiving smoking and tobacco-use cessation counseling services are waived under the Affordable Care Act.

Quitting smoking has immediate as well as long term effects. People who stop smoking greatly reduce their risk of dying prematurely and lower their risk of heart disease, stroke, lung disease, and other health conditions caused by smoking. Benefits are greater for people who stop at earlier ages, but smoking cessation is beneficial at any age.

Older smokers have been shown to be more successful in their attempts to quit than younger smokers and respond favorably to their health care providers' advice to quit smoking. Brief clinical interventions and counseling by health care providers have been shown to increase the chances of successful cessation.

For dates of service on or after March 22, 2005, Medicare began providing coverage of two levels of smoking and tobacco-use cessation counseling (intermediate and intensive) for beneficiaries who use tobacco and have been diagnosed with a recognized tobacco-related disease or who exhibit symptoms consistent with tobacco-related disease.

For dates of service on or after August 25, 2010, the counseling services are expanded to include beneficiaries who do not have signs or symptoms of tobacco-related disease. See the Coverage Information section below.

Cessation Counseling Attempt Defined

A cessation counseling attempt occurs when a qualified physician or other Medicare-recognized practitioner determines that a beneficiary meets the eligibility requirements and initiates treatment with a cessation counseling attempt. A cessation counseling attempt includes the following:

- Up to four cessation counseling sessions (one attempt = up to four sessions)

Two cessation counseling attempts (or up to 8 cessation counseling sessions) are allowed every 12 months.

Cessation Counseling Session Defined

A cessation counseling session refers to face-to-face beneficiary contact at one of two levels:

- Intermediate (greater than 3 minutes and less than 10 minutes), or
- Intensive (greater than 10 minutes).

Cessation counseling sessions may be performed "incident to" the services of a qualified practitioner.

Coverage Information

Medicare provides coverage of smoking and tobacco-use cessation counseling services for beneficiaries:

- Who use tobacco and have been diagnosed with a recognized tobacco-related disease or who exhibit symptoms consistent with tobacco-related disease;
- Who use tobacco, regardless of whether the beneficiary has signs or symptoms of tobacco-related disease;
- Who are competent and alert at the time that counseling is provided; and
- Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

Who Are Physicians and Qualified Non-Physician Practitioners?

Physician

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

Qualified Non-Physician Practitioner

For the purpose of smoking and tobacco-use cessation counseling services and counseling to prevent tobacco use, a qualified non-physician practitioner is a physician assistant, nurse practitioner, or clinical nurse specialist.

Calculating Frequency

Medicare will cover two cessation attempts per year. Each attempt may include a maximum of four intermediate or intensive counseling sessions. The total annual benefit covers up to 8 smoking and tobacco-use cessation counseling sessions in a 12-month period. The beneficiary may receive another 8 counseling sessions during a second or subsequent year after 11 months have passed since the first Medicare-covered cessation counseling session was performed.

When calculating frequency to determine the 11-month period, the count starts with the month after the month in which a previous session was performed.

EXAMPLE: The beneficiary received the first of eight covered sessions in January 2010. The count starts beginning February 2010. The beneficiary is eligible to receive a second series of eight sessions in January 2011.

Stand Alone Benefit

The smoking and tobacco-use cessation counseling and counseling to prevent tobacco use covered by Medicare are stand alone billable services separate from the IPPE and do not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

Reminder

Medicare's Part D prescription drug benefit also covers smoking and tobacco-use cessation agents prescribed by a physician.

During a 12-month period, the practitioner and the beneficiary have the flexibility to choose between intermediate or intensive cessation counseling sessions for each attempt.

NOTE: Medicare covers minimal cessation counseling (defined as three minutes or less in duration) as part of each Evaluation and Management (E/M) visit, and it is not separately billable.

Coinsurance or Copayment and Deductible

Medicare provides coverage for these counseling services as Medicare Part B benefits. For dates of service prior to January 1, 2011, the coinsurance or copayment and the Medicare Part B deductible apply to this benefit. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived for asymptomatic beneficiaries billed to Medicare with Healthcare Common Procedure Coding System (HCPCS) code G0436 or G0437. The waived coinsurance or copayment and deductible does not currently apply to other tobacco-use cessation counseling codes billed to Medicare.

NOTE: The Medicare Part B deductible does not apply to Federally Qualified Health Center (FQHC) services.

Documentation

Medical record documentation must show, for each Medicare beneficiary for whom a smoking and tobacco-use cessation counseling or counseling to prevent tobacco use claim is made, standard information along with sufficient beneficiary history to adequately demonstrate that Medicare coverage conditions were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Current Procedural Terminology (CPT) codes, listed in Table 1, must be used to report smoking and tobacco-use cessation counseling services for beneficiaries who use tobacco and have been diagnosed with a recognized tobacco-related disease or who exhibit symptoms consistent with tobacco-related disease.

Table 1 – CPT Codes for Smoking and Tobacco-Use Cessation Counseling Services for Symptomatic Beneficiaries*

CPT Code	Code Descriptor
99406	Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

***NOTE:** Payment may be allowed for a medically necessary E/M service on the same day as the smoking and tobacco-use cessation counseling service when clinically appropriate. Physicians and qualified non-physician practitioners shall use the appropriate CPT code, such as 99201-99215, to report an E/M service with modifier -25 to indicate that the E/M service is a separately identifiable service from a smoking and tobacco-use cessation counseling service.

The following HCPCS/CPT codes, listed in Table 2, must be used to report counseling to prevent tobacco use for asymptomatic beneficiaries (for dates of service from August 25, 2010, to December 31, 2010).

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Table 2 – HCPCS/CPT Codes for Counseling to Prevent Tobacco Use for Asymptomatic Beneficiaries (for dates of service from August 25, 2010, to December 31, 2010)*

HCPCS/CPT Code	Code Descriptor
C9801	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes **NOTE:** For use by Outpatient Prospective Payment System (OPPS) providers only
C9802	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes **NOTE:** For use by OPPS providers only
99199	Unlisted code

***NOTE:** Payment may be allowed for a medically necessary E/M service on the same day as the counseling to prevent tobacco use service when clinically appropriate. Physicians and qualified non-physician practitioners shall use the appropriate CPT code, such as 99201-99215, to report an E/M service with modifier -25 to indicate that the E/M service is a separately identifiable service from a counseling to prevent tobacco use service.

The following HCPCS codes, listed in Table 3, must be used to report counseling to prevent tobacco use services for asymptomatic beneficiaries (for dates of service on or after January 1, 2011).

Table 3 – HCPCS Codes for Counseling to Prevent Tobacco Use for Asymptomatic Beneficiaries (for dates of service on or after January 1, 2011)*

HCPCS Code	Code Descriptor
G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes

***NOTE:** Payment may be allowed for a medically necessary E/M service on the same day as the counseling to prevent tobacco use service when clinically appropriate. Physicians and qualified non-physician practitioners shall use the appropriate CPT code, such as 99201-99215, to report an E/M service with modifier -25 to indicate that the E/M service is a separately identifiable service from a counseling to prevent tobacco use service.

Diagnosis Requirements

For smoking and tobacco-use cessation counseling services for symptomatic beneficiaries, Medicare providers must submit claims with an appropriate International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code. ICD-9-CM diagnosis codes should reflect the following:

- The condition the beneficiary has that is adversely affected by tobacco use, or
- The condition the beneficiary is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

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For counseling to prevent tobacco use for asymptomatic beneficiaries, Medicare providers must report one of the following ICD-9-CM diagnosis codes, listed in Table 4.

Table 4 – Diagnosis Codes for Counseling to Prevent Tobacco Use for Asymptomatic Beneficiaries

ICD-9-CM Diagnosis Code	Code Descriptor
305.1	Non-dependent tobacco use disorder
V15.82	History of tobacco use

For further guidance, contact the local Medicare Contractor.

Billing Requirements

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

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT code and the corresponding ICD-9-CM diagnosis code in the X12 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

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

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for smoking and tobacco-use cessation counseling services and counseling to prevent tobacco use when submitted on the following TOBs and associated revenue codes, listed in Table 5.

Table 5 – Facility Types, TOBs, and Revenue Codes for Smoking and Tobacco-Use Cessation Counseling Services and Counseling to Prevent Tobacco Use

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B	12X	0942
Hospital Outpatient	13X	0942
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0942
SNF Outpatient	23X	0942
Home Health Agency (HHA)	34X	0942
Rural Health Clinic (RHC)	71X	052X See Additional Billing Instructions for RHCs and FQHCs
Federally Qualified Health Center (FQHC)	77X	052X See Additional Billing Instructions for RHCs and FQHCs
Critical Access Hospital (CAH)*	85X	0942, 096X, 097X, or 098X
Indian Health Service (IHS)	13X	0510
IHS CAH	85X	0510

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

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

Additional Billing Instructions for RHCs and FQHCs

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

There are specific billing and coding requirements for the technical component when a smoking and tobacco-use cessation counseling service or counseling to

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

prevent tobacco use service is furnished in an RHC or an FQHC. The technical component is defined as services rendered outside the scope of the physician's interpretation of the results of an examination.

- **Technical Component** for Provider-Based RHCs and FQHCs:
  - The base provider can bill the technical component of the service to the FI/AB MAC under the base provider's ID number, following instructions for submitting claims to the FI/AB MAC from the base provider.
- **Technical Component** for Independent RHCs and FQHCs:
  - The practitioner can bill the technical component of the service to the carrier/AB MAC under the practitioner's ID number, following instructions for submitting practitioner claims to the carrier/AB MAC.
- **Professional Component for Dates of Service Prior to January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - When a physician or qualified non-physician practitioner furnishes a smoking and tobacco-use cessation counseling service or counseling to prevent tobacco use within an RHC/FQHC, the service is considered an RHC/FQHC service. The provider of the service must bill the FI/AB MAC under TOB 71X or 77X, respectively. The professional portion of the service is billed to the FI/AB MAC using revenue code 052X.
  - When smoking and tobacco-use cessation counseling and counseling to prevent tobacco use are provided by a clinical nurse specialist in the RHC/FQHC setting prior to January 1, 2011, they are considered "incident to" and do not constitute a billable visit.
- **Professional Component for Dates of Service on or After January 1, 2011**, for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - Detailed HCPCS coding is required to ensure that coinsurance or copayment and deductible are not applied to this service. The RHC/FQHC visit should be billed, and payment will be made based on the all-inclusive encounter rate after the application of coinsurance or copayment (and deductible for RHCs). An additional line with revenue code 052X should be submitted with the appropriate HCPCS code for the preventive service and the associated charges. No separate payment will be made for the additional line, as payment is included in the all-inclusive encounter rate, and coinsurance or copayment and deductible will not apply.
  - If the only services provided were preventive, report revenue code 052X with the preventive services HCPCS/CPT code(s). The services reported under the first line will receive an encounter/visit. Coinsurance or copayment and deductible are not applicable.

Reimbursement Information

General Information

Medicare provides coverage of smoking and tobacco-use cessation counseling services as Medicare Part B benefits. For dates of service prior to January 1, 2011, the coinsurance or copayment and the Medicare Part B deductible apply to this benefit. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived for asymptomatic beneficiaries billed to Medicare with HCPCS code G0436 or G0437. The waived coinsurance or copayment and deductible does not currently apply to other tobacco-use cessation counseling codes billed to Medicare.

NOTE: Neither coinsurance, copayment, nor the Medicare Part B deductible apply to this service when provided in an FQHC.

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses smoking and tobacco-use cessation counseling services and counseling to prevent tobacco use under the Medicare Physician Fee Schedule (MPFS).

For claims with dates of service from August 25, 2010, to December 31, 2010, carriers/AB MACs shall pay claims for counseling to prevent tobacco use with unlisted CPT code 99199.

Medicare Physician Fee Schedule (MPFS) Information

For more information about the MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all smoking and tobacco-use cessation counseling services and counseling to prevent tobacco use services.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for smoking and tobacco-use cessation counseling services and counseling to prevent tobacco use depends on the type of facility providing the service. Table 6 lists the type of payment that facilities receive for smoking and tobacco-use cessation counseling and counseling to prevent tobacco use services.

Table 6 – Facility Payment Methodology for Smoking and Tobacco-Use Cessation Counseling Services and Counseling to Prevent Tobacco Use*

Facility Type	Basis of Payment
Hospital Outpatient	Outpatient Prospective Payment System (OPPS) Hospitals not subject to OPPS are paid under the Medicare Physician Fee Schedule (MPFS)
Skilled Nursing Facility (SNF)	MPFS
Home Health Agency (HHA)	MPFS
Rural Health Clinic (RHC)**	All-Inclusive Encounter Rate
Federally Qualified Health Center (FQHC)	All-Inclusive Encounter Rate
Critical Access Hospital (CAH)	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services
Indian Health Service (IHS)/Tribally owned or operated hospital and hospital-based facility	Office of Management & Budget (OMB)-Approved Outpatient per Visit All-Inclusive Rate (AIR)
IHS/Tribally owned or operated non-hospital-based facility	MPFS

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Facility Type	Basis of Payment
IHS/Tribally owned or operated Critical Access Hospital (CAH)	Facility Specific Visit Rate
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	According to the terms of the Maryland waiver

***NOTE:** Inpatient claims submitted with smoking and tobacco-use cessation counseling services and counseling to prevent tobacco use are processed under the current payment methodologies.

****NOTE:** RHCs should include the charges on the claim for future inclusion in encounter rate calculations.

Outpatient Prospective Payment System (OPPS) Information

For more information about OPPS, visit http://www.cms.gov/HospitalOutpatientPPS on the CMS website.

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of smoking and tobacco-use cessation counseling sessions and counseling to prevent tobacco use:

- The beneficiary dates of service exceed a combined total of 8 sessions in a 12-month period.
- The beneficiary did not meet the eligibility requirements for this service.
- The beneficiary has reached the maximum therapeutic benefit.

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Tobacco-Use Cessation Counseling Services

Resources

Agency for Healthcare Research and Quality Treating Tobacco Use and Dependence: 2008 Update
http://www.ahrq.gov/path/tobacco.htm

American Lung Association Tobacco Control Advocacy
http://www.lungusa.org/stop-smoking/tobacco-control-advocacy

Centers for Disease Control and Prevention (CDC) Smoking and Tobacco Use
http://www.cdc.gov/tobacco

CMS Smoking Cessation Web Page
http://www.cms.gov/SmokingCessation

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 32, Section 12
http://www.cms.gov/manuals/downloads/clm104c32.pdf

Medicare Learning Network® (MLN) "Smoking and Tobacco-Use Cessation Counseling Services" Brochure (ICN 006767)
http://www.cms.gov/MLNProducts/downloads/smoking.pdf

"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.4
http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

MLN Matters® Article MM7133, "Counseling to Prevent Tobacco Use"
http://www.cms.gov/MLNMattersArticles/downloads/MM7133.pdf

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

National Cancer Institute Tobacco and Cancer Information Resources
http://www.cancer.gov/cancertopics/tobacco/smoking

National Cancer Institute Tobacco Control Research
http://dccps.nci.nih.gov/tcrb

Office of the Surgeon General Tobacco Cessation Guidelines
http://www.surgeongeneral.gov/tobacco

Smokefree.gov
http://smokefree.gov

USPSTF Recommendations
This website provides the USPSTF written recommendations on counseling to prevent tobacco use in adults and pregnant women.
http://www.uspreventiveservicestaskforce.org/uspstf/uspstbac2.htm

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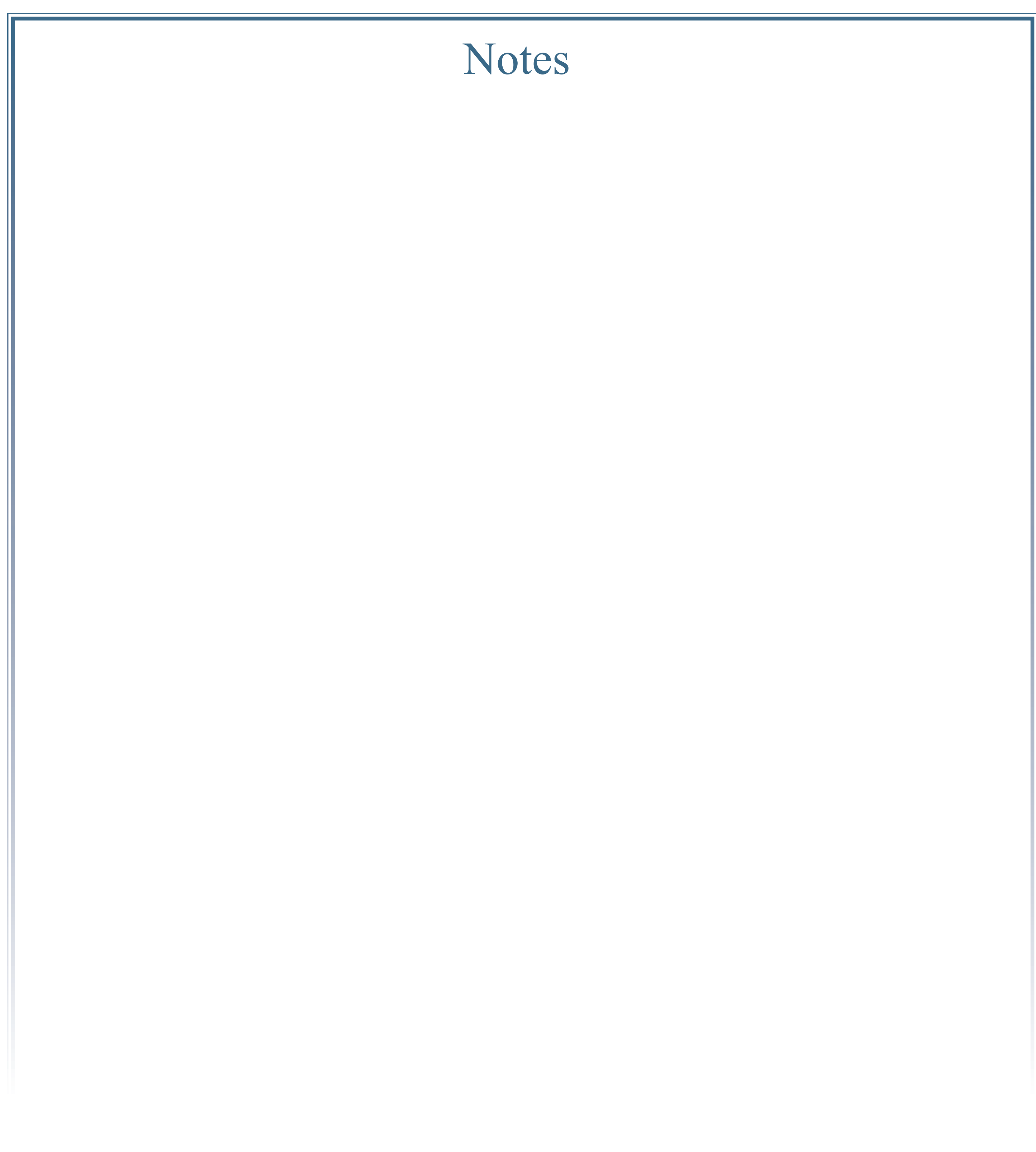
More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.

Notes



Notes

Reference A
Acronyms

Acronym	Description
AAA	Abdominal Aortic Aneurysm
AADE	American Association of Diabetes Educators
AAO	American Academy of Ophthalmology
AB MAC	Part A and Part B Medicare Administrative Contractor
ACIP	Advisory Committee on Immunization Practices
ACS	American Cancer Society
ADA	American Diabetes Association
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immunodeficiency Syndrome
AIR	All-Inclusive Rate
AMA	American Medical Association
ANSI	American National Standards Institute
APC	Ambulatory Payment Classification
ARNP	Advanced Registered Nurse Practitioner
ASC	Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ATS	American Thoracic Society
AWP	Average Wholesale Price
AWV	Annual Wellness Visit
BMM	Bone Mass Measurement
BNI	Beneficiary Notices Initiative
BUD	Bone Ultrasound Densitometry
CAD	Computer-Aided Detection
CAH	Critical Access Hospital
CARC	Claim Adjustment Reason Code
CBA	Competitive Bidding Area
CCI	Correct Coding Initiative
CDC	Centers for Disease Control and Prevention

Acronym	Description
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CLFS	Clinical Laboratory Fee Schedule
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
CNS	Clinical Nurse Specialist
CO	Central Office (CMS Central Office)
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CSII	Continuous Subcutaneous Insulin Infusion
CWF	Common Working File
DES	Diethylstilbestrol
DEXA	Dual Energy X-ray Absorptiometry
DFARS	Defense Federal Acquisition Regulation System
DME	Durable Medical Equipment
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DNA	Deoxyribonucleic Acid
DRE	Digital Rectal Examination
DRG	Diagnosis-Related Group
DSMO	Designated Standard Maintenance Organization
DSMT	Diabetes Self-Management Training
DXA	Dual-Energy X-ray Absorptiometry
ECG	Electrocardiogram
EDI	Electronic Data Interchange
EIA	Enzyme Immunoassay
EKG	Electrocardiogram
ELISA	Enzyme-Linked Immunosorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim
ERT	Estrogen Replacement Therapy

Acronym	Description
ESRD	End-Stage Renal Disease
FARS	Federal Acquisition Regulation System
FDA	Food and Drug Administration
FECA	Federal Employees' Compensation Act
FFS	Fee-For-Service
FI	Fiscal Intermediary
FOBT	Fecal Occult Blood Test
FQHC	Federally Qualified Health Center
GFR	Glomerular Filtration Rate
GTT	Glucose Tolerance Test
HBV	Hepatitis B Virus
HCPCS	Healthcare Common Procedure Coding System
HDL	High Density Lipoprotein
HHA	Home Health Agency
HHS	Department of Health and Human Services
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HSCRC	Health Services Cost Review Commission
IAC	Immunization Action Coalition
ICD	International Classification of Diseases
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
IDSA	Infectious Diseases Society of America
IgG	Immunoglobulin G
IgM	Immunoglobulin M
IHS	Indian Health Service
IOM	Internet-Only Manual
IOP	Intraocular Pressure
IPPE	Initial Preventive Physical Examination

Acronym	Description
LCD	Local Coverage Determination
LCSW	Licensed Clinical Social Worker
LDL	Low Density Lipoprotein
MAC	Medicare Administrative Contractor
MedQIC	Medicare Quality Improvement Community
MLN	Medicare Learning Network®
MNT	Medical Nutrition Therapy
MPFS	Medicare Physician Fee Schedule
MQSA	Mammography Quality Standards Act
MSA	Metropolitan Statistical Area
MSN	Medicare Summary Notice
NCCI	National Correct Coding Initiative
NCD	National Coverage Determination
NCHS	National Centers for Health Statistics
NCI	National Cancer Institute
NDIC	National Diabetes Information Clearinghouse
NEI	National Eye Institute
NEMB	Notice of Exclusion for Medicare Benefits
NFID	National Foundation for Infectious Diseases
NHLBI	National Heart, Lung, and Blood Institute
NIH	National Institutes of Health
NNII	National Network for Immunization Information
NPI	National Provider Identifier
NUBC	National Uniform Billing Committee
OMB	Office of Management and Budget
OPPS	Outpatient Prospective Payment System
OPT	Outpatient Physical Therapy
PA	Physician Assistant
PC	Professional Component
PHS	Public Health Service

Acronym	Description
POS	Place of Service
PPPS	Personalized Prevention Plan Services
PPS	Prospective Payment System
PPV	Pneumococcal Polysaccharide Vaccine
PSA	Prostate Specific Antigen
QCT	Quantitative Computed Tomography
RA	Remittance Advice
RARC	Remittance Advice Remark Code
RDF	Renal Dialysis Facility
RHC	Rural Health Clinic
RNA	Ribonucleic Acid
SCHIP	State Children’s Health Insurance Program
SEXA	Single Energy X-ray Absorptiometry
SHIP	State Health Insurance Assistance Program
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility
SNIP	Strategic National Implementation Process
SSA	Social Security Act
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TC	Technical Component
TOB	Type of Bill
UPIN	Unique Physician Identification Number
URAC	Utilization Review Accreditation Commission
USPSTF	United States Preventive Services Task Force
WHO	World Health Organization
WPC	Washington Publishing Company

Notes

Reference B
Glossary

A

Abdominal Aortic Aneurysm (AAA) - An aneurysm that occurs in the aorta in the abdomen is called an AAA. Medicare pays for a one-time preventive ultrasound screening for the early detection of AAAs for at-risk beneficiaries, resulting from a referral from an Initial Preventive Physical Examination (IPPE).

Accredited (Accreditation) - Having a seal of approval. Being accredited means a facility or health care organization has met certain quality standards. These standards are set by private, nationally recognized groups that check on the quality of care at health care facilities and organizations. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (URAC).

Acquired Immunodeficiency Syndrome (AIDS) - Diagnosed when a Human Immunodeficiency Virus (HIV)-infected person's immune system becomes severely compromised and/or a person becomes ill with an HIV-related opportunistic infection.

Act/Law/Statute - The term for legislation that passed through Congress and was signed by the President or passed over the President's veto.

Actual Charge - The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves.

Administrative Simplification Compliance Act (ASCA) - Signed into law on December 27, 2001, as Public Law 107-105, this Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Consequently, unless a provider fits one of the exceptions, any paper claims that are submitted to Medicare will not be paid.

Advisory Committee on Immunization Practices (ACIP) - Committee that develops written recommendations for the routine administration of vaccines to pediatric and adult populations, along with schedules regarding the appropriate periodicity, dosage, and contraindications applicable to the vaccines. ACIP is the only entity in the Federal Government that makes such recommendations.

Affordable Care Act - The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Agency for Healthcare Research and Quality (AHRQ) - The Department of Health and Human Services (HHS) agency responsible for improving the quality, safety, efficiency, and effectiveness of health care for all Americans by supporting research that helps people make more informed decisions and improves the quality of health care services.

Allowed Amount - Individual charge determined by a carrier/AB Medicare Administrative Contractor (AB MAC) for a covered Supplementary Medical Insurance (SMI) medical service or supply.

Ambulatory Surgical Center (ASC) - A freestanding facility, other than a hospital or physician's office, where outpatient surgical and diagnostic services are provided. At an ambulatory (in and out) surgery center, the beneficiary may stay for only a few hours or for one night.

Annual Wellness Visit (AWV), Providing Personalized Prevention Plan Services (PPPS) - Section 4103 of the Affordable Care Act expanded preventive services to include coverage for dates of service on or after January 1, 2011, under Medicare Part B, of an AWV, providing PPPS with the goal of health promotion and disease detection and fostering coordination of the screening and preventive services that may already be covered and paid for under Medicare Part B.

ANSI X12N 835 - The required electronic transaction format for Health Care Claim Payment/Advice submissions.

ANSI X12N 837 - The required electronic transaction format for Health Care Claims.

Approved Amount/Charge - The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by the beneficiary and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Assessment - The gathering of information to rate or evaluate a beneficiary's health and needs, such as in a nursing home.

Assignment - Agreement by a physician, provider, or supplier to accept the Medicare Fee Schedule amount as payment in full for the rendered service. The physician or supplier must submit the claim for the patient, and the payment is remitted directly to the physician or supplier.

Attending Physician - A doctor of medicine or osteopathy, who is fully knowledgeable about the beneficiary's medical condition, and who is responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

B

Barium Enema - A procedure in which the beneficiary is given an enema with barium. X-rays are taken of the colon that allow the physician to see the outline of the beneficiary's colon to check for polyps or other abnormalities.

Beneficiary - An individual who is entitled to Medicare Part A and/or Medicare Part B.

Billing Providers - The provider who submits a claim for payment on services he/she has performed or, in some cases, the group, such as a clinic, bills for the performing providers within the group.

Bone Density Studies (Bone Mass Measurements) - Tests used to measure bone density in the spine, hip, calcaneus, and/or wrist, the most common sites of fractures due to osteoporosis.

Bone Ultrasound Densitometry (BUD) - The established standard for measuring bone mineral density, most commonly measured in the heel or the tibia.

Bundled - Refers to a group of services listed under one code.

C

Cardiovascular Screening Blood Test - A preventive service provided by Medicare that tests triglyceride, high-density lipoprotein, and total cholesterol levels to identify possible risk factors for cardiovascular disease.

Carrier - A contractor for the Centers for Medicare & Medicaid Services (CMS) that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments.

Centers for Disease Control and Prevention (CDC) - The Department of Health and Human Services (HHS) agency responsible for monitoring health, detecting and investigating health problems, conducting research to enhance prevention, developing and advocating sound public health policies, implementing prevention strategies, promoting healthy behaviors, fostering safe and healthful environments, and providing leadership and training.

Centers for Medicare & Medicaid Services (CMS) - The Department of Health and Human Services (HHS) agency responsible for administering Medicare and working with State departments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

Centralized Billing - An optional program for providers who qualify to enroll with Medicare as the provider type "mass immunizer." Additional criteria must also be met.

Certified - A hospital that has passed a survey done by a State Government agency. Being certified is not the same as being accredited. Medicare only covers care in hospitals that are certified or accredited.

Claim Adjustment Reason Codes (CARCs) - A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is used in the American National Standards Institute (ANSI) X12N 835 Claim Payment & Remittance Advice and the ANSI X12N 837 Claim transactions, and is maintained by the Health Care Code Maintenance Committee.

Coinsurance (Medicare Private Fee-For-Service Plan) - The percentage of the Private Fee-For-Service Plan charge for services that beneficiaries may have to pay after they pay any plan deductibles. In a Private Fee-For-Service Plan, the coinsurance payment is a percentage of the cost of the service (e.g., 20 percent) - the percent of the Medicare-approved amount that beneficiaries pay after satisfying the deductible for Part A and/or Part B.

Coinsurance (Outpatient Prospective Payment System [OPPS]) - The percentage of the Medicare payment rate or a hospital's billed charge that beneficiaries have to pay after they pay the deductible for Medicare Part B services.

Colonoscopy - A procedure used to check for polyps or cancer in the rectum and the entire colon.

Common Working File (CWF) - A database containing Medicare eligibility and usage data for each beneficiary. The file helps reduce claims overpayment and provides the most current and accurate data on Medicare beneficiaries.

Comprehensive Outpatient Rehabilitation Facility (CORF) - A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.

Computer-Aided Detection (CAD) - The use of a laser beam to scan the mammography film from a film (analog) mammography, to convert it into digital data for the computer, and to analyze the video display for areas suspicious for cancer.

Contractor - An entity that has an agreement with the Centers for Medicare & Medicaid Services (CMS) or another funding agency to perform a project.

Copayment - In some Medicare health plans, the amount that is paid by the beneficiary for each medical service, like a doctor's visit. A copayment is usually a set amount paid for a service. For example, this could

be $10 or $20 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Correct Coding Initiative (CCI) - A series of edits developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims.

Covered Benefit - A health service or item that is included in a health plan and that is paid for either partially or fully.

Critical Access Hospital (CAH) - A small facility that gives limited outpatient and inpatient hospital services to individuals in rural areas.

Current Procedural Terminology (CPT) - A medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of the Department of Health and Human Services (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 (HHS) - The United States Government's principal agency for providing essential human services. HHS includes more than 300 programs, including Medicare, Medicaid, and the Centers for Disease Control and Prevention (CDC). HHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. (It is the "parent" of the Centers for Medicare & Medicaid Services [CMS].)

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, and
- Motivation for beneficiaries to use the skills for self-management.

Diagnosis Code - The first of these codes is the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization). The remaining codes are the ICD-9-CM diagnosis codes corresponding to additional conditions that coexisted at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.

Diagnosis-Related Group (DRG) - A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Diagnostic Mammography - Mammography used to diagnose unusual breast changes, such as a lump, pain, thickening, nipple discharge, or a change in breast size or shape. A diagnostic mammogram is also used to evaluate changes detected on a screening mammogram.

Dialysis Facility (Renal) - A unit (hospital-based or freestanding) that is approved to furnish dialysis services directly to End-Stage Renal Disease (ESRD) patients.

Diethylstilbestrol (DES) - A drug given to pregnant women from the early 1940s until 1971 to help with common problems during pregnancy. The drug has been linked to cancer of the cervix or vagina in women whose mothers took the drug while pregnant. A synthetic compound used as a potent estrogen but contraindicated in pregnancy for its tendency to cause cancer or birth defects in offspring.

Dietitian/Nutritionist - A specialist in the study of nutrition.

Digital Rectal Examination (DRE) - A clinical examination of the prostate for abnormalities such as swelling and nodules of the prostate gland.

Dilated Eye Examination - An examination of the eye involving the use of medication to enlarge the pupils, which allows more of the eye to be seen.

Direct Ophthalmoscopic Examination - An examination of the eye using an ophthalmoscope, an instrument for viewing the interior of the eye.

Dual Energy X-ray Absorptiometry (DEXA or DXA) - X-ray densitometry that measures the bone mass in the spine, hip, or total body.

Durable Medical Equipment (DME) - Medical equipment that is ordered by a doctor (or, if Medicare allows, a nurse practitioner, physician assistant, or clinical nurse specialist) for use in the home. A hospital or nursing home that mostly provides skilled care cannot qualify as a "home" in this situation. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

Durable Medical Equipment Medicare Administrative Contractor (DME MAC) - A contractor for the Centers for Medicare & Medicaid Services (CMS) that provides Medicare claims processing and payment of Durable Medical Equipment (DME), prosthetics, orthotics, and supplies for a designated region of the country.

Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) - Purchased or rented items that are covered by Medicare, such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a beneficiary's home.

Durometer - A measure of surface resistivity or material hardness.

E

Electrocardiogram (EKG or ECG) - A graphical recording of the cardiac cycle produced by an electrocardiograph, an instrument used in the detection and diagnosis of heart abnormalities.

Electronic Data Interchange (EDI) - The automated transfer of data in a specific format following specific data content rules between a health care provider and Medicare, or between Medicare and another health care plan.

Electronic Media Claim (EMC) - A flat file format used to transmit or transport claims.

End-Stage Renal Disease (ESRD) - Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Enzyme Immunoassay (EIA) - An immunoassay technique used to detect antibodies to Human Immunodeficiency Virus (HIV).

Enzyme-Linked Immunosorbent Assay (ELISA) - An immunoassay technique used to detect antibodies to Human Immunodeficiency Virus (HIV).

Evaluation and Management (E/M) - A review of a beneficiary's systems and/or past, family, or social history.

F

Fasting Blood Glucose Test - A measurement of blood glucose level taken after the beneficiary has not eaten for 8 to 12 hours (usually overnight). This test is used to diagnose pre-diabetes and diabetes. It is also used to monitor individuals with diabetes.

Fecal Occult Blood Test (FOBT) - A test that checks for occult or hidden blood in the stool.

Federally Qualified Health Center (FQHC) - A health center that has been approved by the Federal Government for a program to serve underserved areas and populations. Medicare pays for a full range of practitioner services (physician and qualified non-physician) in FQHCs as well as certain preventive health services that are not usually covered under Medicare. FQHCs include community health centers, migrant health services, health centers for the homeless, and tribal health clinics.

Fee Schedule - A complete listing of fees used by health plans to pay doctors or other providers.

Fiscal Intermediary (FI) - A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

Flexible Sigmoidoscopy - A procedure used to check for polyps or cancer in the rectum and the lower third of the colon.

Food and Drug Administration (FDA) - Federal agency that is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, food supply, cosmetics, and products that emit radiation.

Form CMS-855 - The form used to enroll in Medicare.

Form CMS-1450 - The form used to bill the Fiscal Intermediary (FI)/AB Medicare Administrative Contractor (AB MAC) for services provided to a Medicare beneficiary.

Form CMS-1500 - The form used to bill the carrier/AB Medicare Administrative Contractor (AB MAC) for services provided to a Medicare beneficiary.

G

Global Component - When referencing billing/payment requirements, the combination of both the technical and professional components.

Government Entities - Entities, such as public health clinics, that may bill Medicare for influenza, pneumococcal, and hepatitis B vaccines administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

H

Healthcare Common Procedure Coding System (HCPCS) - A uniform method for providers and suppliers to report professional services, procedures, and supplies. HCPCS includes Current Procedural Technology (CPT) codes (Level I), national alphanumeric codes (Level II), and local codes (Level III) assigned and maintained by local Medicare Contractors.

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 Claim Number (HICN) - A unique 10- or 11-digit alphanumeric Medicare entitlement number assigned to a Medicare beneficiary; appears on the Medicare Health Insurance card.

Hepatitis B Vaccine - A vaccine administered to prevent Hepatitis B Virus (HBV) infection.

Hepatitis B Virus (HBV) - A serious disease caused by a virus that attacks the liver. It can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

Home Health Agency (HHA) - An organization that gives home care services, such as skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Home Health Care - Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, Durable Medical Equipment (DME) (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice - A facility providing pain relief, symptom management, and supportive services to terminally ill people and their families; an eligible beneficiary must have a life expectancy of six months or less. Hospice care is covered under Medicare Part A (Hospital Insurance).

Hospital Insurance (Part A) - The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Human Immunodeficiency Virus (HIV) - The virus that causes Acquired Immunodeficiency Syndrome (AIDS).

Human Papillomavirus (HPV) - Genital human papillomavirus (also called HPV) is the most common Sexually Transmitted Infection (STI). There are more than 40 HPV types that can infect the genital areas of males and females. These HPV types can also infect the mouth and throat. Most people who become infected with HPV do not even know they have it.

I

Immunoassay - A test that uses the binding of antibodies to antigens to identify and measure certain substances. Immunoassays may be used to diagnose disease and can aid in planning treatment.

Immunosuppressive Drugs - Drugs used to reduce the risk of rejecting new organs after transplant. Transplant patients will need to take these drugs for the rest of their lives.

Indian Health Service (IHS) - An agency within the Department of Health and Human Services (HHS) responsible for providing Federal health services to American Indians and Alaskan Natives.

Influenza - Also known as the flu virus, is a contagious disease that is caused by the influenza virus. It attacks the respiratory tract in humans (nose, throat, and lungs). Influenza is a serious illness that can lead to pneumonia.

Influenza Vaccine - A vaccine administered to prevent influenza virus infection.

Infusion Pumps - Pumps used for giving fluid or medication intravenously at a specific rate or over a set amount of time.

Initial Preventive Physical Examination (IPPE) - Medicare covers a one-time IPPE, also referred to as the “Welcome to Medicare” visit. The IPPE must be received within 12 months of the beneficiary’s

Medicare Part B effective date. The goals of the IPPE are health promotion and disease detection, and include education, counseling, end-of-life planning, and referral to screening and preventive services also covered under Medicare Part B.

International Classification of Diseases (ICD) - A medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set was to classify causes of death. A United States extension, maintained by the National Centers for Health Statistics (NCHS) within the Centers for Disease Control and Prevention (CDC), identifies morbidity factors or diagnoses. The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes have been selected for use in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions.

Internet-Only Manual (IOM) - Online manuals containing program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives.

Intraocular Pressure Measurement (IOP Measurement) - A measurement of the intraocular pressure in the eye; used as a part of a preventive glaucoma screening.

L

Limiting Charge - In the Original Medicare Plan, the highest amount of money that can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Local Coverage Determination (LCD) - A decision by a Fiscal Intermediary(FI)/AB Medicare Administrative Contractor (AB MAC) or carrier/AB MAC that determines whether to cover a particular service on an intermediary-wide or carrier-wide basis.

M

Mammography Quality Standards Act (MQSA) - Informs mammography facility personnel, inspectors, and other interested individuals about mammography quality standards.

Mass Immunization Center - A location where providers administer pneumococcal and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or use the roster billing method. This generally takes place in a mass immunization setting such as a public health center, pharmacy, or mall, but may include a physician's office setting.

Mass Immunizer - A provider who chooses to enroll in Medicare with this identifier, which demands that the provider meet certain criteria and follow certain procedures when immunizing Medicare beneficiaries.

Medically Necessary - Services or supplies that:

- Are proper and needed for the diagnosis or treatment of a medical condition;
- Are provided for the diagnosis, direct care, and treatment of a medical condition;
- Meet the standards of good medical practice in the medical community of the local area; and
- Are not mainly for the convenience of the patient or doctor.

Medical Nutrition Therapy (MNT) - Nutritional therapy covered by Medicare for beneficiaries diagnosed with diabetes or a renal disease. For the purpose of disease management, covered MNT services include:

- An initial nutrition and lifestyle assessment,

- Nutrition counseling,
- Information regarding diet management, and
- Follow-up sessions to monitor progress.

Medicare Administrative Contractor (MAC) - The contracting organization that is responsible for the receipt, processing, and payment of Medicare claims. In addition to providing core claims processing operations for both Medicare Part A and Part B, they will perform functions related to: Beneficiary and Provider Service, Appeals, Provider Outreach and Education (also referred to as Provider Education and Training), Financial Management, Program Evaluation, Reimbursement, Payment Safeguards, and Information Systems Security.

Medicare Clinical Laboratory Fee Schedule (CLFS) - A complete listing of fees that Medicare uses to pay clinical laboratories.

Medicare Contractor - A Medicare Part A Fiscal Intermediary (FI) (institutional), Medicare Part B Carrier (professional), Medicare Administrative Contractor (AB MAC), or Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

Medicare Coverage - Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). (See: Medicare Part A [Hospital Insurance]; Medicare Part B [Medical Insurance].)

Medicare Learning Network® (MLN) - The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at http://www.cms.gov/MLNGenInfo on the CMS website.

Medicare Part A - Hospital insurance that pays for inpatient hospital stays, care in a Skilled Nursing Facility (SNF), hospice care, and some home health care.

Medicare Part B - Medical insurance that helps pay for doctors' services, outpatient hospital care, Durable Medical Equipment (DME), and some medical services that are not covered by Part A.

Medicare Physician Fee Schedule (MPFS) - A complete list of medical procedure codes and the maximum dollar amounts Medicare will allow for each service rendered for a beneficiary.

N

National Coverage Determination (NCD) - Policies set by the Centers for Medicare & Medicaid Services (CMS) that state whether specific medical items, services, treatment procedures, or technologies can be paid for under Medicare.

National Institutes of Health (NIH) - The Department of Health and Human Services (HHS) agency responsible for conducting and supporting research in the causes, diagnosis, prevention, and cure of human diseases; in the processes of human growth and development; in the biological effects of environmental contaminants; in the understanding of mental, addictive and physical disorders; and in directing programs for the collection, dissemination, and exchange of information in medicine and health, including the development and support of medical libraries and the training of medical librarians and other health information specialists.

National Provider Identifier (NPI) - A 10-digit provider identification number that replaced all legacy transaction numbers (e.g., Unique Provider Identification Numbers [UPINs], Blue Cross and Blue Shield numbers, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) numbers, and Medicaid numbers) in all standardized Medicare transactions.

Non-Assigned Claim - A type of claim that directs payment to the beneficiary and may only be filed by a non-participating Medicare physician; when a claim is filed non-assigned the beneficiary is reimbursed directly.

Non-Government Entities - Entities that do not charge patients who are unable to pay, or reduce charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided. These entities may bill Medicare and expect payment.

Non-Participating Physician/Supplier - A physician practice/supplier that has not elected to become a Medicare participating physician/supplier (i.e., one that has retained the right to accept assignment on a case-by-case basis [compared to a participating physician]).

Non-Physician Practitioner - A health care provider who meets State licensing requirements to provide specific medical services. Medicare allows payment for services furnished by qualified non-physician practitioners, including, but not limited to: Advanced Registered Nurse Practitioners (ARNPs), Clinical Nurse Specialists (CNSs), Licensed Clinical Social Workers (LCSWs), Physician Assistants (PAs), nurse midwives, physical therapists, and audiologists.

Nurse Practitioner - A nurse who has two or more years of advanced training and has passed a special examination. A nurse practitioner often works with a doctor and can do some of the same things a doctor does.

O

Original Medicare Plan - A pay-per-visit health plan that lets beneficiaries go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. Beneficiaries must pay the deductible. Medicare pays its share of the Medicare-approved amount, and beneficiaries pay their share (coinsurance). In some cases, they may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Orthotist - An individual who provides a range of splints, braces, and special footwear to aid movement, correct deformity, and relieve discomfort.

Outpatient Hospital Services - Medical or surgical care that Medicare Part B helps pay for that does not include an overnight hospital stay. These services include:

- Blood transfusions;
- Certain drugs;
- Hospital billed laboratory tests;
- Mental health care;
- Medical supplies such as splints and casts;
- Emergency room or outpatient clinic, including same day surgery; and
- X-rays and other radiation services.

Outpatient Prospective Payment System (OPPS) - The PPS under Medicare that determines payment for hospital outpatient services, certain Part B services furnished to hospital inpatients who have no Part A coverage, and partial hospitalization services furnished by community mental health centers.

P

Pap Test - A test used to check for cancer of the cervix, the opening to a woman's womb. The test is performed by removing cells from the cervix and preparing the cells so they can be seen under a microscope.

Participating Physician/Supplier - A physician practice/supplier that has elected to provide all Medicare Part B services on an assigned basis for a specified period of time.

Pedorthist - An individual who is trained in the assessment, design, manufacture, fit, and modification of foot appliances and footwear for the purposes of alleviating painful or debilitating conditions and providing assistance for abnormalities or limited actions of the lower limb.

Pelvic Exam - An examination to check if internal female organs are normal by feeling the shape and size of the organs.

Photodensitometry - A method of using an X-ray source, radiographic film, and a known standard with which to compare the bones being analyzed. This technique is also called radiodensitometry.

Physical Therapy - Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage.

Place of Service - Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.

Plan of Care - A plan by a diabetic beneficiary's managing physician required for coverage of Diabetes Self-Management Training (DSMT) services by Medicare. This plan of care must describe the content, number of sessions, frequency, and duration of the training written by the physician (or qualified non-physician practitioner). The plan of care must also include a statement by the physician (or qualified non-physician practitioner) and the signature of the physician (or qualified non-physician practitioner) denoting any changes to the plan of care.

Pneumococcal Diseases (pneumonia) - Infections caused by the bacteria Streptococcus pneumoniae, also known as pneumococcus. The most common types of infections caused by this bacterium include middle ear infections, pneumonia, blood stream infections (bacteremia), sinus infections, and meningitis.

Pneumococcal Polysaccharide Vaccine (PPV) - A vaccine administered to prevent pneumococcal diseases.

Post-Glucose Challenge - A measurement of blood glucose taken one hour after the ingestion of a liquid containing glucose.

Preventive Services - Health care services provided to beneficiaries to maintain health or to prevent illness. Examples include Pap screening tests, pelvic exams, mammograms, and influenza virus vaccinations.

Primary Care Physician - A physician who is trained to provide basic care. This includes being the first to check on health problems and coordinating preventive health care with other doctors, specialists, and therapists.

Professional Component (PC) - When referencing billing/payment requirements, the physician's interpretation of the results of the examination.

Prospective Payment System (PPS) - A system of Medicare payment that is 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.

Prosthetist - An individual who provides the best possible artificial replacement for patients who have lost or were born without a limb. A prosthetic limb should feel and look like a natural limb.

Provider - Any Medicare provider (e.g., hospital, Skilled Nursing Facility [SNF], Home Health Agency [HHA], Outpatient Physical Therapy [OPT], Comprehensive Outpatient Rehabilitation Facility [CORF], End-Stage Renal Disease [ESRD] facility, hospice, physician, qualified non-physician practitioner, laboratory, supplier) providing medical services covered under Medicare Part B. Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, Ambulatory Surgical Centers (ASCs), and outpatient clinics are some of the providers of services covered under Medicare Part B.

Q

Quantitative Computed Tomography (QCT) - Bone mass measurement most commonly used to measure the spine (but can also be used at other sites).

R

Reasonable Cost - The Centers for Medicare & Medicaid Services (CMS) guidelines used by Fiscal Intermediaries (FIs), carriers, and AB Medicare Administrative Contractors (AB MACs) to determine reasonable costs incurred by individual providers in furnishing covered services to enrollees.

Referral - A plan may restrict certain health care services to an enrollee unless the enrollee receives a referral from a plan-approved caregiver, on paper, referring them to a specific place/person for the service. Generally, a referral is defined as an actual document obtained from a provider in order for the beneficiary to receive additional services.

Regional Office - The Centers for Medicare & Medicaid Services (CMS) has 10 Regional Offices that work closely together with Medicare Contractors in their assigned geographical areas on a day-to-day basis. Four of these Regional Offices monitor network contractor performance, negotiate contractor budgets, distribute administrative monies to contractors, work with contractors when corrective actions are needed, and provide a variety of other liaison services to the contractors in their respective regions.

Remittance Advice (RA) - Statement sent to providers that explains the reimbursement decision made by the payment contractor. This explanation may include the reasons for payments, denials, and/or adjustments for processed claims. Also serves as a companion to claim payments.

Remittance Advice Remark Codes (RARCs) - Codes used within the American National Standards Institute (ANSI) X12N 835 transaction to convey information about remittance processing or to provide a supplemental explanation for an adjustment.

Renal Dialysis Facility (RDF) - A unit (hospital based or freestanding) that is approved to furnish dialysis services directly to End-Stage Renal Disease (ESRD) beneficiaries.

Revenue Codes - Payment codes for services or items (e.g., 042X, 043X) found in Medicare and/or National Uniform Billing Committee (NUBC) manuals.

Roster Billing - Also referred to as simplified roster billing; a process developed by the Centers for Medicare & Medicaid Services (CMS) that enables entities that accept assignment, who administer the influenza virus and/or pneumococcal vaccine to multiple beneficiaries, to bill Medicare for payment using a modified CMS-1450 or CMS-1500 claim form.

Rural Health Clinic (RHC) - An outpatient facility that is primarily engaged in furnishing physicians and other medical and health services and that meets other requirements designated to ensure the health and

safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the United States Bureau of Census.

S

Screening Diagnosis Code - A code assigned to the medical terminology used for each service and/or item provided by a provider or health care facility (as noted in the medical records) (e.g., the screening diagnosis code for preventive glaucoma screening is V80.1 [Special Screening for Neurological, Eye, and Ear Disease, Glaucoma]). Diagnosis codes are based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

Screening Mammography - A mammogram performed on an asymptomatic female beneficiary to detect the presence of breast cancer at an early stage.

Single Energy X-ray Absorptiometry (SEXA) - A method of bone mass measurement that measures the wrist or heel.

Skilled Nursing Facility (SNF) - An institution or distinct part of an institution having a transfer agreement with one or more hospitals; primarily engaged in providing inpatient skilled nursing care or rehabilitation services.

Slit-Lamp Biomicroscopic Examination - An examination of the eye with a low-power binocular microscope placed horizontally and used with a slit lamp for detailed examination of the back part of the eye.

T

Technical Component (TC) - When referencing billing/payment requirements, all other services outside of the physician's interpretation of the results of the examination.

Type of Bill (TOB) Code - This four-digit alphanumeric code gives three specific pieces of information after a leading zero. The Centers for Medicare & Medicaid Services (CMS) will ignore the leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" 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" Visit - Medicare covers a one-time Initial Preventive Physical Examination (IPPE), also referred to as the "Welcome to Medicare" visit. The IPPE must be received within 12 months of the beneficiary's Medicare Part B effective date. The goals of the IPPE are health promotion and disease detection, and include education, counseling, end-of-life planning, and referral to screening and preventive services also covered under Medicare Part B.

World Health Organization (WHO) - An organization that maintains the International Classification of Diseases (ICD) medical code set.

X

X12N - An American National Standards Institute (ANSI)-accredited group that defines Electronic Data Interchange (EDI) standards for many American industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under Health Insurance Portability and Accountability Act of 1996 (HIPAA) are X12 standards.

Notes

Notes

Reference C
Centers for Medicare & Medicaid Services (CMS) Websites and Contact Information

Table 1 – CMS Websites

Resource	Website
Clinical Laboratory Improvement Amendments (CLIA)	http://www.cms.gov/clia
CMS Acronym List	http://www.cms.gov/apps/acronyms
CMS Adult Immunization Website	http://www.cms.gov/AdultImmunizations
CMS Beneficiary Notices Initiative (BNI)	http://www.cms.gov/BNI
CMS Carrier/Fiscal Intermediary Toll-Free Number Directory	http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip
CMS Clinical Laboratory Fee Schedule Information	http://www.cms.gov/ClinicalLabFeeSched/01_overview.asp
CMS Contact Information	http://www.cms.gov/ContactCMS
CMS Coverage Database	http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx
CMS E-Mail Updates Subscription Service	Subscribe to an e-mail update list to receive the latest CMS news: http://www.cms.gov/AboutWebsite/20_EmailUpdates.asp
CMS Electronic Claim Submission Information	http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp
CMS Fee-For-Service (FFS) Provider Listservs	Subscribe to the most appropriate FFS provider listserv: http://www.cms.gov/prospmedicarefeesvcpmtgen/downloads/Provider_Listservs.pdf
CMS Forms	http://www.cms.gov/CMSForms CMS-1500: http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp CMS-1450: http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp
CMS Glossary	http://www.cms.gov/apps/glossary
CMS Healthcare Common Procedure Coding System (HCPCS) Information	http://www.cms.gov/MedHCPCSGenInfo

Resource	Website
CMS Home Page	http://www.cms.gov
CMS ICD-9-CM	http://www.cms.gov/ICD9ProviderDiagnosticCodes
CMS ICD-9-CM Coordination and Maintenance Committee Meetings	http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp
CMS Internet-Only Manuals	http://www.cms.gov/manuals/IOM/list.asp
CMS Medicare Contracting Reform	http://www.cms.gov/MedicareContractingReform
CMS Medicare Fee-For-Service Provider/Supplier Enrollment	http://www.cms.gov/MedicareProviderSupEnroll
CMS Medicare Fee-For-Service Provider/Supplier Enrollment Forms	http://www.cms.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp
CMS Prevention Web Pages	http://www.cms.gov/home/medicare.asp
CMS Quality Initiatives General Information	http://www.cms.gov/QualityInitiativesGenInfo
CMS Regional Offices - Information for Professionals	http://www.cms.gov/consortia
"Documentation Guidelines for Evaluation and Management (E/M) Services"	http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp
Medicaid – List of State Health Departments	http://www.cms.gov/apps/contacts
"Medicare Benefit Policy Manual"	http://www.cms.gov/manuals/IOM/list.asp
"Medicare Claims Processing Manual"	http://www.cms.gov/manuals/IOM/list.asp
Medicare Fee-For-Service Providers Website	http://www.cms.gov/center/provider.asp
Medicare Learning Network® (MLN)	http://www.cms.gov/MLNGenInfo
"Medicare National Coverage Determination Manual"	http://www.cms.gov/manuals/IOM/list.asp
Medicare Physician Fee Schedule (MPFS)	http://www.cms.gov/PhysicianFeeSched
Medicare Preventive Benefits Outreach Materials for Providers	http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
Medicare Preventive Services General Information	http://www.cms.gov/PrevntionGenInfo

Resource	Website
MLN Influenza (Flu) Season Educational Products and Resources	http://www.cms.gov/MLNProducts/Downloads/flu_products.pdf
MLN Matters® Articles	http://www.cms.gov/MLNMattersArticles
MLN Matters® Articles Related to Medicare-Covered Preventive Benefits	http://www.cms.gov/MLNProducts/Downloads/MLNPrevArticles.pdf
National Correct Coding Initiative (NCCI) Edits Website	http://www.cms.gov/NationalCorrectCodInitEd
Open Door Forums	These free events/teleconferences provide an opportunity for live dialogue between CMS and the community. http://www.cms.gov/OpenDoorForums
Outpatient Prospective Payment System (OPPS)	http://www.cms.gov/HospitalOutpatientPPS
Physician Center Web Page	http://www.cms.gov/center/physician.asp
Physician Fee Schedule Federal Regulation Notices	http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp
Remittance Advice Information	http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

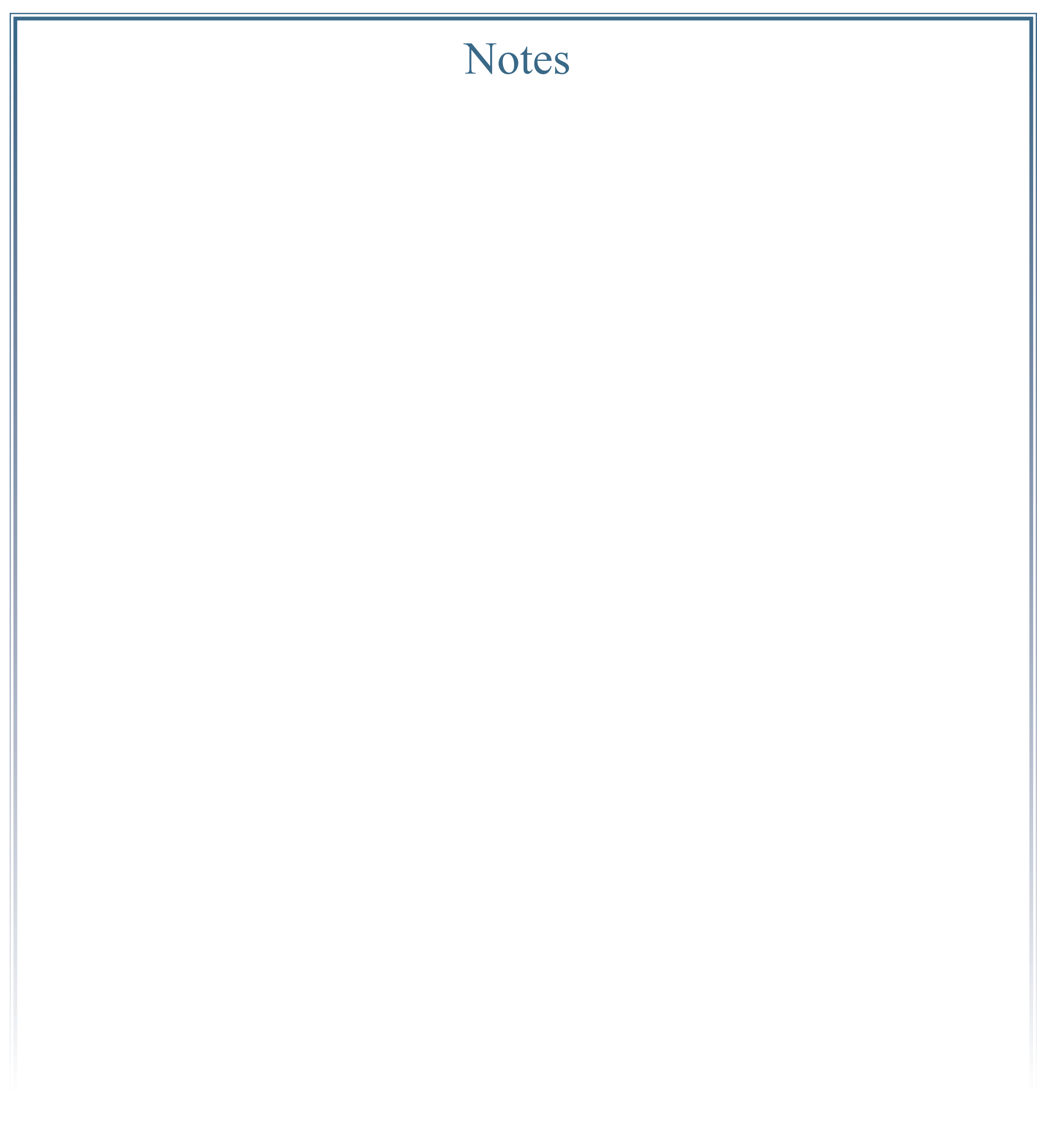
Table 2 – Health Insurance Portability and Accountability Act of 1996 (HIPAA) Contact Information

Resource	Contact Information
CMS Health Insurance Portability and Accountability Act of 1996 (HIPAA) Website	http://www.cms.gov/HIPAAGenInfo
CMS HIPAA Experts - E-mail Address	AskHIPAA@cms.gov
HIPAA Administrative Simplification Hotline	1-866-282-0659
The Strategic National Implementation Process (SNIP) Website	http://www.wedi.org/snip
Designated Standard Maintenance Organizations (DSMOs) Website	http://www.hipaa-dsmo.org

Table 3 – CMS Contact Information

CMS Baltimore Headquarters	Contact Information
Centers for Medicare & Medicaid Services Central Office	Toll-Free: 1-877-267-2323 Local: 410-786-3000 TTY Toll-Free: 1-866-226-1819 TTY Local: 410-786-0727

Notes



Notes

Reference D
Provider Educational Resources

Medicare Fee-For-Service (FFS) Provider Educational Products List

Please Note:

The products listed here are for provider use only and are not intended for distribution to Medicare beneficiaries. For a list of beneficiary reference materials, please see Reference F in this Guide.

The "Guide to Medicare Preventive Services" (The Guide) is part of a comprehensive provider education and information program designed to:

1. Ensure Medicare Fee-For-Service (FFS) Providers have the information they need to properly bill for preventive services and screenings covered by Medicare; and
2. Promote increased awareness and utilization of these benefits and encourage providers to talk with their Medicare patients about prevention, early detection, and the importance of taking full advantage of Medicare preventive benefits for which they may be eligible.

In addition to The Guide, the Centers for Medicare & Medicaid Services (CMS) has developed a variety of products to educate providers and their staff about coverage, coding, billing, and payment for Medicare preventive services and screenings, including:

- A Dedicated Educational Web Page – The Medicare Learning Network® (MLN) Preventive Services Educational Products web page is a one-stop shop for provider educational information on coverage, coding, and billing of Medicare-covered preventive benefits. The web page contains a descriptive listing of the products, which include articles, a guide, brochures, quick reference educational tools, web-based training courses, a CD ROM, and seasonal flu information, as well as product ordering information and links to other related CMS and non-CMS prevention resources and websites.

  http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
- MLN Matters® Articles – National articles specifically for health care professionals about Medicare preventive services and screenings.
- Quick Reference Information Educational Tools – "Quick Reference Information: Medicare Preventive Services," "Quick Reference Information: Medicare Immunization Billing," "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination," and "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit (AWV)."
- A Series of Brochures – "Adult Immunizations," "Bone Mass Measurements," "Cancer Screenings," "Diabetes-Related Services," "Glaucoma Screening," and "Smoking and Tobacco-Use Cessation Counseling Services."
- CD ROM – This CD contains Portable Document Format (PDF) files of all the Medicare Preventive Services educational products including The Guide, quick reference information educational tools, and brochures.

- A Series of Three Web-Based Training Courses – Medicare Preventive Services Series Web-Based Training Courses (Parts 1, 2, and 3), each approved by CMS for continuing education credits for successful completion.

Many of the print products are available in hard copy and downloadable PDF Internet files. Ordering information for all products listed here as well as links to online products can be found on the dedicated MLN Preventive Services Educational Products web page at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp on the CMS website. **All products are available, free of charge, from the Medicare Learning Network®.**

The educational tools on the following pages are for provider use only and are not intended for distribution to Medicare beneficiaries. On the next pages, you will find copies of the following provider resources:

- "Quick Reference Information: Medicare Preventive Services"
- "Quick Reference Information: Medicare Immunization Billing"
- "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination"
- "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit"
- Table 1: Medicare Preventive Services Cost Sharing Information for Dates of Service Prior to January 1, 2011
- Table 2: Medicare Preventive Services Cost Sharing Information for Dates of Service on or After January 1, 2011
- Table 3: Medicare Preventive Services – Internet-Only Manual (IOM) and MLN Matters® Article References

For information appropriate for beneficiary distribution, refer to Reference F of this Guide, "Resources for Medicare Beneficiaries."

Quick Reference Information: Medicare Preventive Services

Medicare PREVENTIVE SERVICES — Quick Reference Information: Preventive Services

This educational tool provides information on Medicare preventive services. Information provided includes Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes; International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes; coverage requirements; frequency requirements; and beneficiary liability for each Medicare preventive service.

SERVICE	HCPCS/CPT CODES	ICD-9-CM CODES	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
Initial Preventive Physical Examination (IPPE) **Also known as the "Welcome to Medicare Visit"**	G0402 – IPPE G0403 – ECG for IPPE G0404 – ECG tracing for IPPE G0405 – ECG interpret & report **Important** – The screening EKG is an optional service that may be performed as a result of a referral from an IPPE	No specific diagnosis code Contact the local Medicare Contractor for guidance	All Medicare beneficiaries whose first Part B coverage began on or after 01/01/05	Once in a lifetime benefit per beneficiary **Must be furnished no later than 12 months after the effective date of the first Medicare Part B coverage**	**G0402 prior to 01/01/11:** • Copayment/coinsurance applies • Deductible waived **G0402 on or after 01/01/11:** • Copayment/coinsurance waived • Deductible waived **G0403, G0404, G0405:** • Copayment/coinsurance applies • Deductible applies
Annual Wellness Visit (AWV) **This is a new benefit beginning for dates of service on and after 01/01/11**	G0438 – First visit G0439 – Subsequent visit	No specific diagnosis code Contact the local Medicare Contractor for guidance	All Medicare beneficiaries who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not received an IPPE or AWV within the past 12 months	• Once in a lifetime for G0438 • Annually for G0439	**Prior to 01/01/11:** • N/A **On or after 01/01/11:** • Copayment/coinsurance waived • Deductible waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389 – Ultrasound exam AAA screen	No specific diagnosis code Contact the local Medicare Contractor for guidance	Medicare beneficiaries with certain risk factors for abdominal aortic aneurysm **Important** – Eligible beneficiaries must receive a referral for an AAA ultrasound screening as a result of an IPPE	Once in a lifetime benefit per eligible beneficiary	**Prior to 01/01/11:** • Copayment/coinsurance applies • Deductible waived **On or after 01/01/11:** • Copayment/coinsurance waived • Deductible waived
Cardiovascular Disease Screenings	80061 – Lipid Panel 82465 – Cholesterol 83718 – Lipoprotein 84478 – Triglycerides	Report one or more of the following codes: V81.0, V81.1, V81.2	All Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease **12-hour fast is required prior to testing**	Every 5 years	• Copayment/coinsurance waived • Deductible waived
Diabetes Screening Tests	82947 – Glucose, quantitative, blood (except reagent strip) 82950 – Glucose, post-glucose dose (includes glucose) 82951 – Glucose Tolerance Test (GTT), three specimens (includes glucose)	V77.1	Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes **Beneficiaries previously diagnosed with diabetes are not eligible for this benefit**	• 2 screening tests per year for beneficiaries diagnosed with pre-diabetes • 1 screening per year if previously tested, but not diagnosed with pre-diabetes, or if never tested	• Copayment/coinsurance waived • Deductible waived
Diabetes Self-Management Training (DSMT)	G0108 – DSMT, individual session, per 30 minutes G0109 – DSMT, group session (2 or more), per 30 minutes	No specific diagnosis code Contact the local Medicare Contractor for guidance	Medicare beneficiaries diagnosed with diabetes **Must be ordered by the physician or qualified non-physician practitioner treating the beneficiary's diabetes**	• Up to 10 hours of initial training within a continuous 12-month period • Subsequent years: Up to 2 hours of follow-up training each year after the initial year	• Copayment/coinsurance applies • Deductible applies
Medical Nutrition Therapy (MNT)	97802, 97803, 97804, G0270, G0271 **Services must be provided by a registered dietitian or nutrition professional**	No specific diagnosis code Contact the local Medicare Contractor for guidance	Certain Medicare beneficiaries diagnosed with diabetes, renal disease, or who have received a kidney transplant within the last three years	• 1st year: 3 hours of one-on-one counseling • Subsequent years: 2 hours	**Prior to 01/01/11:** • Copayment/coinsurance applies • Deductible applies **On or after 01/01/11:** • Copayment/coinsurance waived • Deductible waived
Screening Pap Tests	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	Report one of the following codes: V76.2, V76.47, V76.49, V15.89, V72.31	All female Medicare beneficiaries	• Annually if at high-risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years • Every 24 months for all other women	**G0124, G0141, P3001, Q0091 prior to 01/01/11:** • Copayment/coinsurance applies • Deductible waived **All other codes prior to 01/01/11:** • Copayment/coinsurance waived • Deductible waived **All codes on or after 01/01/11:** • Copayment/coinsurance waived • Deductible waived

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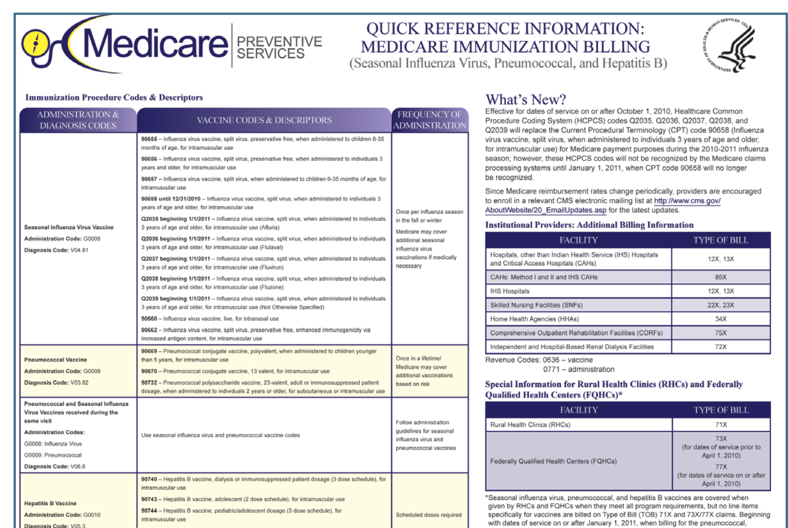
The "Quick Reference Information: Medicare Preventive Services" educational tool provides quick reference to Medicare's preventive services. This educational tool may be viewed, downloaded, and printed by clicking on the image. To access this educational tool online, visit http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf on the CMS website.

Quick Reference Information: Medicare Immunization Billing


Medicare PREVENTIVE SERVICES

QUICK REFERENCE INFORMATION:
MEDICARE IMMUNIZATION BILLING
(Seasonal Influenza Virus, Pneumococcal, and Hepatitis B)

Immunization Procedure Codes & Descriptors

ADMINISTRATION & DIAGNOSIS CODES	VACCINE CODES & DESCRIPTORS	FREQUENCY OF ADMINISTRATION
Seasonal Influenza Virus Vaccine **Administration Code:** G0008 **Diagnosis Code:** V04.81	**90655** – Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use **90656** – Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use **90657** – Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use **90658 until 12/31/2010** – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use **Q2035 beginning 1/1/2011** – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria) **Q2036 beginning 1/1/2011** – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval) **Q2037 beginning 1/1/2011** – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirun) **Q2038 beginning 1/1/2011** – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone) **Q2039 beginning 1/1/2011** – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified) **90660** – Influenza virus vaccine, live, for intranasal use **90662** – Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	Once per influenza season in the fall or winter Medicare may cover additional seasonal influenza virus vaccinations if medically necessary
Pneumococcal Vaccine **Administration Code:** G0009 **Diagnosis Code:** V03.82	**90669** – Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use **90670** – Pneumococcal conjugate vaccine, 13 valent, for intramuscular use **90732** – Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	Once in a lifetime/ Medicare may cover additional vaccinations based on risk
Pneumococcal and Seasonal Influenza Virus Vaccines received during the same visit **Administration Codes:** G0008: Influenza Virus G0009: Pneumococcal **Diagnosis Code:** V06.6	Use seasonal influenza virus and pneumococcal vaccine codes	Follow administration guidelines for seasonal influenza virus and pneumococcal vaccines
Hepatitis B Vaccine **Administration Code:** G0010 **Diagnosis Code:** V05.3	**90740** – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use **90743** – Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use **90744** – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use **90746** – Hepatitis B vaccine, adult dosage, for intramuscular use **90747** – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use	Scheduled doses required

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What's New?

Effective for dates of service on or after October 1, 2010, Healthcare Common Procedure Coding System (HCPCS) codes Q2035, Q2036, Q2037, Q2038, and Q2039 will replace the Current Procedural Terminology (CPT) code 90658 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use) for Medicare payment purposes during the 2010-2011 influenza season; however, these HCPCS codes will not be recognized by the Medicare claims processing systems until January 1, 2011, when CPT code 90658 will no longer be recognized.

Since Medicare reimbursement rates change periodically, providers are encouraged to enroll in a relevant CMS electronic mailing list at http://www.cms.gov/AboutWebsite/20_EmailUpdates.asp for the latest updates.

Institutional Providers: Additional Billing Information

FACILITY	TYPE OF BILL
Hospitals, other than Indian Health Service (IHS) Hospitals and Critical Access Hospitals (CAHs)	12X, 13X
CAHs: Method I and II and IHS CAHs	85X
IHS Hospitals	12X, 13X
Skilled Nursing Facilities (SNFs)	22X, 23X
Home Health Agencies (HHAs)	34X
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	75X
Independent and Hospital-Based Renal Dialysis Facilities	72X

Revenue Codes: 0636 – vaccine
0771 – administration

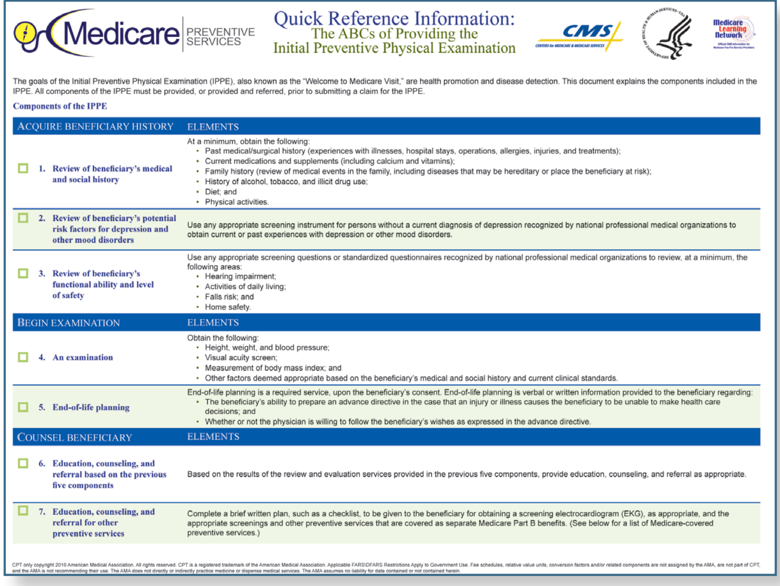
Special Information for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)*

FACILITY	TYPE OF BILL
Rural Health Clinics (RHCs)	71X
Federally Qualified Health Centers (FQHCs)	73X (for dates of service prior to April 1, 2010) 77X (for dates of service on or after April 1, 2010)

*Seasonal influenza virus, pneumococcal, and hepatitis B vaccines are covered when given by RHCs and FQHCs when they meet all program requirements, but no line items specifically for vaccines are billed on Type of Bill (TOB) 71X and 73X/77X claims. Beginning with dates of service on or after January 1, 2011, when billing for the pneumococcal, seasonal influenza virus, and hepatitis B vaccine and their administration on TOB 77X, the services should be reported separately with the appropriate HCPCS code and revenue codes. The cost of the seasonal influenza virus and pneumococcal vaccines and the vaccine administration is reported separately on the RHC's and FQHC's cost report for reimbursement purposes.

The "Quick Reference Information: Medicare Immunization Billing" educational tool provides quick information to assist with filing claims for the seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. This educational tool may be viewed, downloaded, and printed by clicking on the image. To access this educational tool online, visit http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf on the CMS website.

Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination


Medicare PREVENTIVE SERVICES

Quick Reference Information:
The ABCs of Providing the
Initial Preventive Physical Examination

The goals of the Initial Preventive Physical Examination (IPPE), also known as the "Welcome to Medicare Visit," are health promotion and disease detection. This document explains the components included in the IPPE. All components of the IPPE must be provided, or provided and referred, prior to submitting a claim for the IPPE.

Components of the IPPE

ACQUIRE BENEFICIARY HISTORY	ELEMENTS
1. Review of beneficiary's medical and social history	At a minimum, obtain the following: • Past medical/surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments); • Current medications and supplements (including calcium and vitamins); • Family history (review of medical events in the family, including diseases that may be hereditary or place the beneficiary at risk); • History of alcohol, tobacco, and illicit drug use; • Diet; and • Physical activities.
2. Review of beneficiary's potential risk factors for depression and other mood disorders	Use any appropriate screening instrument for persons without a current diagnosis of depression recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders.
3. Review of beneficiary's functional ability and level of safety	Use any appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas: • Hearing impairment; • Activities of daily living; • Falls risk; and • Home safety.
BEGIN EXAMINATION	**ELEMENTS**
4. An examination	Obtain the following: • Height, weight, and blood pressure; • Visual acuity screen; • Measurement of body mass index; and • Other factors deemed appropriate based on the beneficiary's medical and social history and current clinical standards.
5. End-of-life planning	End-of-life planning is a required service, upon the beneficiary's consent. End-of-life planning is verbal or written information provided to the beneficiary regarding: • The beneficiary's ability to prepare an advance directive in the case that an injury or illness causes the beneficiary to be unable to make health care decisions; and • Whether or not the physician is willing to follow the beneficiary's wishes as expressed in the advance directive.
COUNSEL BENEFICIARY	**ELEMENTS**
6. Education, counseling, and referral based on the previous five components	Based on the results of the review and evaluation services provided in the previous five components, provide education, counseling, and referral as appropriate.
7. Education, counseling, and referral for other preventive services	Complete a brief written plan, such as a checklist, to be given to the beneficiary for obtaining a screening electrocardiogram (EKG), as appropriate, and the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits. (See below for a list of Medicare-covered preventive services.)

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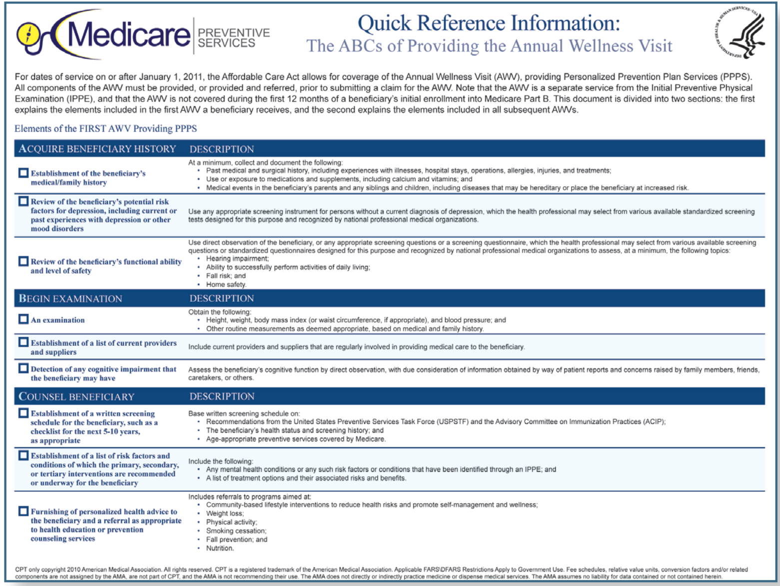
The "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination" educational tool identifies the components and elements of the IPPE and provides eligibility requirements, procedure codes to use when filing claims, Frequently Asked Questions (FAQs), suggestions for preparing patients for the IPPE, and lists resources for additional information. This educational tool may be viewed, downloaded, and printed by clicking on the image. To access this educational tool online, visit http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf on the CMS website.

Quick Reference Information: The ABCs of Providing the Annual Wellness Visit



Medicare PREVENTIVE SERVICES

Quick Reference Information:
The ABCs of Providing the Annual Wellness Visit

For dates of service on or after January 1, 2011, the Affordable Care Act allows for coverage of the Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS). All components of the AWV must be provided, or provided and referred, prior to submitting a claim for the AWV. Note that the AWV is a separate service from the Initial Preventive Physical Examination (IPPE), and that the AWV is not covered during the first 12 months of a beneficiary's initial enrollment into Medicare Part B. This document is divided into two sections: the first explains the elements included in the first AWV a beneficiary receives, and the second explains the elements included in all subsequent AWVs.

Elements of the FIRST AWV Providing PPPS

Acquire Beneficiary History	Description
☐ Establishment of the beneficiary's medical/family history	At a minimum, collect and document the following: • Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments; • Use or exposure to medications and supplements, including calcium and vitamins; and • Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the beneficiary at increased risk.
☐ Review of the beneficiary's potential risk factors for depression, including current or past experiences with depression or other mood disorders	Use any appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.
☐ Review of the beneficiary's functional ability and level of safety	Use direct observation of the beneficiary, or any appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations to assess, at a minimum, the following topics: • Hearing impairment; • Ability to successfully perform activities of daily living; • Fall risk; and • Home safety.
Begin Examination	**Description**
☐ An examination	Obtain the following: • Height, weight, body mass index (or waist circumference, if appropriate), and blood pressure; and • Other routine measurements as deemed appropriate, based on medical and family history.
☐ Establishment of a list of current providers and suppliers	Include current providers and suppliers that are regularly involved in providing medical care to the beneficiary.
☐ Detection of any cognitive impairment that the beneficiary may have	Assess the beneficiary's cognitive function by direct observation, with due consideration of information obtained by way of patient reports and concerns raised by family members, friends, caretakers, or others.
Counsel Beneficiary	**Description**
☐ Establishment of a written screening schedule for the beneficiary, such as a checklist for the next 5-10 years, as appropriate	Base written screening schedule on: • Recommendations from the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP); • The beneficiary's health status and screening history; and • Age-appropriate preventive services covered by Medicare.
☐ Establishment of a list of risk factors and conditions of which the primary, secondary, or tertiary interventions are recommended or underway for the beneficiary	Include the following: • Any mental health conditions or any such risk factors or conditions that have been identified through an IPPE; and • A list of treatment options and their associated risks and benefits.
☐ Furnishing of personalized health advice to the beneficiary and a referral as appropriate to health education or prevention counseling services	Includes referrals to programs aimed at: • Community-based lifestyle interventions to reduce health risks and promote self-management and wellness; • Weight loss; • Physical activity; • Smoking cessation; • Fall prevention; and • Nutrition.

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The "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" educational tool identifies the elements of the AWV and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the AWV, and lists resources for additional information. This educational tool may be viewed, downloaded, and printed by clicking on the image. To access this educational tool online, visit http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf on the CMS website.

Table 1 - Medicare Preventive Services Cost Sharing Information for Dates of Service Prior to January 1, 2011

Preventive Benefit	Copayment/Coinsurance/Deductible
Bone Mass Measurements	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Cardiovascular Screening Blood Tests	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Colorectal Cancer Screening	For the Fecal Occult Blood Test (FOBT), the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the flexible sigmoidoscopy, coinsurance or copayment applies and the Medicare Part B deductible is waived. If the screening is performed in a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount. For the colonoscopy, coinsurance or copayment applies and the Medicare Part B deductible is waived. If the screening is performed in a hospital outpatient department, the beneficiary pays 25% of the Medicare-approved amount. If the screening is performed in a Critical Access Hospital (CAH), the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the barium enema, coinsurance or copayment applies and the Medicare Part B deductible is waived. If the screening is performed in a CAH, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Diabetes Screening	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Diabetes Self-Management Training (DSMT)	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Diabetes Supplies	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Glaucoma Screening	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Hepatitis B Virus (HBV) Vaccination	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Human Immunodeficiency Virus (HIV) Screening	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Initial Preventive Physical Examination (IPPE)/“Welcome to Medicare” Visit	For dates of service between January 1, 2009, and January 1, 2011, the deductible for the IPPE only is waived (not the screening electrocardiogram [EKG]). Coinsurance or copayment still applies to both the IPPE and the screening EKG.

Preventive Benefit	Copayment/Coinsurance/Deductible
Medical Nutrition Therapy (MNT)	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Pneumococcal Vaccination	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Prostate Cancer Screening	For the screening Prostate Specific Antigen (PSA) blood test, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the Digital Rectal Examination (DRE), both the coinsurance or copayment and the Medicare Part B deductible apply.
Screening Mammography	Coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived.
Screening Pap Test	For screening Pap test services paid under the Medicare Physician Fee Schedule (MPFS), the coinsurance or copayment applies and the Medicare Part B deductible is waived. For screening Pap test services paid under the Clinical Laboratory Fee Schedule, both the coinsurance or copayment and the Medicare Part B deductible are waived.
Screening Pelvic Examination (includes a clinical breast examination)	Coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived.
Seasonal Influenza Virus Vaccination	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Smoking and Tobacco-Use Cessation Counseling Services and Counseling to Prevent Tobacco Use	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	Coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived.

Table 2 - Medicare Preventive Services Cost Sharing Information for Dates of Service on or After January 1, 2011

Preventive Benefit	Copayment/Coinsurance/Deductible
Annual Wellness Visit (AWV)	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Bone Mass Measurements	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).

Preventive Benefit	Copayment/Coinsurance/Deductible
Cardiovascular Screening Blood Tests	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Colorectal Cancer Screening	For the Fecal Occult Blood Test (FOBT), flexible sigmoidoscopy, and colonoscopy, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the barium enema, coinsurance or copayment applies and the Medicare Part B deductible is waived. If the screening is performed in a Critical Access Hospital (CAH), the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Diabetes Screening	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Diabetes Self-Management Training (DSMT)	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Diabetes Supplies	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Glaucoma Screening	Both the coinsurance or copayment and Medicare Part B deductible apply.
Hepatitis B Virus (HBV) Vaccination	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Human Immunodeficiency Virus (HIV) Screening	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Initial Preventive Physical Examination (IPPE)/"Welcome to Medicare" Visit	The beneficiary will pay nothing for the IPPE (there is no coinsurance or copayment and no Medicare Part B deductible). Coinsurance or copayment and the Medicare Part B deductible still apply to the screening electrocardiogram (EKG).
Medical Nutrition Therapy (MNT)	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Pneumococcal Vaccination	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Prostate Cancer Screening	For the screening Prostate Specific Antigen (PSA) blood test, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the Digital Rectal Examination (DRE), both the coinsurance or copayment and the Medicare Part B deductible apply.
Screening Mammography	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Screening Pap Test	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).

Preventive Benefit	Copayment/Coinsurance/Deductible
Screening Pelvic Examination (includes a clinical breast examination)	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Seasonal Influenza Virus Vaccination	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Tobacco-Use Cessation Counseling Services	Asymptomatic beneficiaries will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). (See Chapter 15 for more information.)
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).

Table 3 - Medicare Preventive Services – Internet-Only Manual (IOM) and MLN Matters® Article References

Preventive Benefit	Reference
Preventive Services	"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18 http://www.cms.gov/manuals/downloads/clm104c18.pdf MLN Matters® Article MM7012, "Waiver of Coinsurance and Deductible for Preventive Services, Section 4104 of the Affordable Care Act, Removal of Barriers to Preventive Services in Medicare" http://www.cms.gov/MLNMattersArticles/downloads/MM7012.pdf MLN Matters® Article MM7038, "Affordable Care Act Mandated Collection of Federally Qualified Health Center (FQHC) Data and Updates to Preventive Services Provided by FQHCs" http://www.cms.gov/MLNMattersArticles/downloads/MM7038.pdf MLN Matters® Article MM7208, "Waiver of Coinsurance and Deductible for Preventive Services for Rural Health Clinics (RHCs), Section 4104 of the Affordable Care Act" http://www.cms.gov/MLNMattersArticles/downloads/MM7208.pdf MLN Matters® Articles on Preventive Services http://www.cms.gov/MLNProducts/Downloads/MLNPrevArticles.pdf

Preventive Benefit	Reference
Annual Wellness Visit (AWV)	"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 280.5 http://www.cms.gov/manuals/downloads/bp102c15.pdf "Medicare Claims Processing Manual" – Publication 100-04, Chapter 12, Section 30.6.1.1 http://www.cms.gov/manuals/downloads/clm104c12.pdf "Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 140 http://www.cms.gov/manuals/downloads/clm104c18.pdf MLN Matters® Article MM7079, "Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)" http://www.cms.gov/MLNMattersArticles/downloads/MM7079.pdf
Bone Mass Measurements	"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 80.5 http://www.cms.gov/manuals/downloads/bp102c15.pdf "Medicare Claims Processing Manual" – Publication 100-04, Chapter 13, Section 140 http://www.cms.gov/manuals/downloads/clm104c13.pdf Local Coverage Determinations (LCDs) http://www.cms.gov/DeterminationProcess/04_LCDs.asp
Cardiovascular Screening Blood Tests	"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 100 http://www.cms.gov/manuals/downloads/clm104c18.pdf
Colorectal Cancer Screening	"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 280.2 http://www.cms.gov/manuals/downloads/bp102c15.pdf "Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 60 http://www.cms.gov/manuals/downloads/clm104c18.pdf MLN Matters® Article MM6760, "Use of 12X Type of Bill (TOB) for Billing Colorectal Screening Services" http://www.cms.gov/MLNMattersArticles/downloads/MM6760.pdf MLN Matters® Article MM6578, "Screening Computed Tomography Colonography (CTC) for Colorectal Cancer" http://www.cms.gov/MLNMattersArticles/downloads/MM6578.pdf
Diabetes Screening	"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 90 http://www.cms.gov/manuals/downloads/clm104c18.pdf

Preventive Benefit	Reference
Diabetes Self-Management Training (DSMT)	"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 300 http://www.cms.gov/manuals/downloads/bp102c15.pdf "Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 120 http://www.cms.gov/manuals/downloads/clm104c18.pdf MLN Matters® Article MM6510, "Diabetes Self-Management Training (DSMT) Certified Diabetic Educator" http://www.cms.gov/MLNMattersArticles/downloads/MM6510.pdf
Glaucoma Screening	"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 280.1 http://www.cms.gov/manuals/downloads/bp102c15.pdf "Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 70 http://www.cms.gov/manuals/downloads/clm104c18.pdf
Human Immunodeficiency Virus (HIV) Screening	"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 130 http://www.cms.gov/manuals/downloads/clm104c18.pdf "Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 3, Sections 190.13 and 190.14 http://www.cms.gov/manuals/downloads/ncd103c1_Part3.pdf "Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.7 http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf MLN Matters® Article MM6786, "Screening for Human Immunodeficiency Virus (HIV) Infection" http://www.cms.gov/MLNMattersArticles/downloads/MM6786.pdf

Preventive Benefit	Reference
Immunizations (Seasonal Influenza Virus, Pneumococcal, and Hepatitis B Virus [HBV])	"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 50.4.4.2 http://www.cms.gov/manuals/downloads/bp102c15.pdf "Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 10 http://www.cms.gov/manuals/downloads/clm104c18.pdf MLN Matters® Article MM7124, "2010 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations" http://www.cms.gov/MLNMattersArticles/downloads/MM7124.pdf MLN Matters® Article MM7234, "New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines" http://www.cms.gov/MLNMattersArticles/downloads/MM7234.pdf MLN Matters® Article SE1026, "Important News About Flu Shot Frequency for Medicare Beneficiaries" http://www.cms.gov/MLNMattersArticles/downloads/SE1026.pdf MLN Matters® Article SE1031, "2010-2011 Seasonal Influenza (Flu) Resources for Health Care Professionals" http://www.cms.gov/MLNMattersArticles/downloads/SE1031.pdf "2010-2011 Immunizers' Question & Answer Guide to Medicare Part B & Medicaid Coverage of Seasonal Influenza and Pneumococcal Vaccinations" http://www.cms.gov/AdultImmunizations/Downloads/20102011ImmunizersGuide.pdf
Initial Preventive Physical Examination (IPPE)/"Welcome to Medicare" Visit	"Medicare Claims Processing Manual" – Publication 100-04, Chapter 12, Section 30.6.1.1 http://www.cms.gov/manuals/downloads/clm104c12.pdf "Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 80 http://www.cms.gov/manuals/downloads/clm104c18.pdf MLN Matters® Article SE0918, "Value of Family History under the Initial Preventive Physical Exam (IPPE) Benefit" http://www.cms.gov/MLNMattersArticles/downloads/SE0918.pdf
Medical Nutrition Therapy (MNT)	"Medicare Claims Processing Manual" – Publication 100-04, Chapter 4, Section 300 http://www.cms.gov/manuals/downloads/clm104c04.pdf
Prostate Cancer Screening	"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 50 http://www.cms.gov/manuals/downloads/clm104c18.pdf "Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.1 http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

Preventive Benefit	Reference
Screening Mammography	"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 280.3 http://www.cms.gov/manuals/downloads/bp102c15.pdf "Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 20 http://www.cms.gov/manuals/downloads/clm104c18.pdf "Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 220.4 http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
Screening Pap Test	"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 280.4 http://www.cms.gov/manuals/downloads/bp102c15.pdf "Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 30 http://www.cms.gov/manuals/downloads/clm104c18.pdf "Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.2 http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
Screening Pelvic Examination (includes a clinical breast examination)	"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 40 http://www.cms.gov/manuals/downloads/clm104c18.pdf "Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.2 http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
Tobacco-Use Cessation Counseling Services	"Medicare Claims Processing Manual" – Publication 100-04, Chapter 32, Section 12 http://www.cms.gov/manuals/downloads/clm104c32.pdf "Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.4 http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf MLN Matters® Article – MM7133, "Counseling to Prevent Tobacco Use" http://www.cms.gov/MLNMattersArticles/downloads/MM7133.pdf
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 110 http://www.cms.gov/manuals/downloads/clm104c18.pdf

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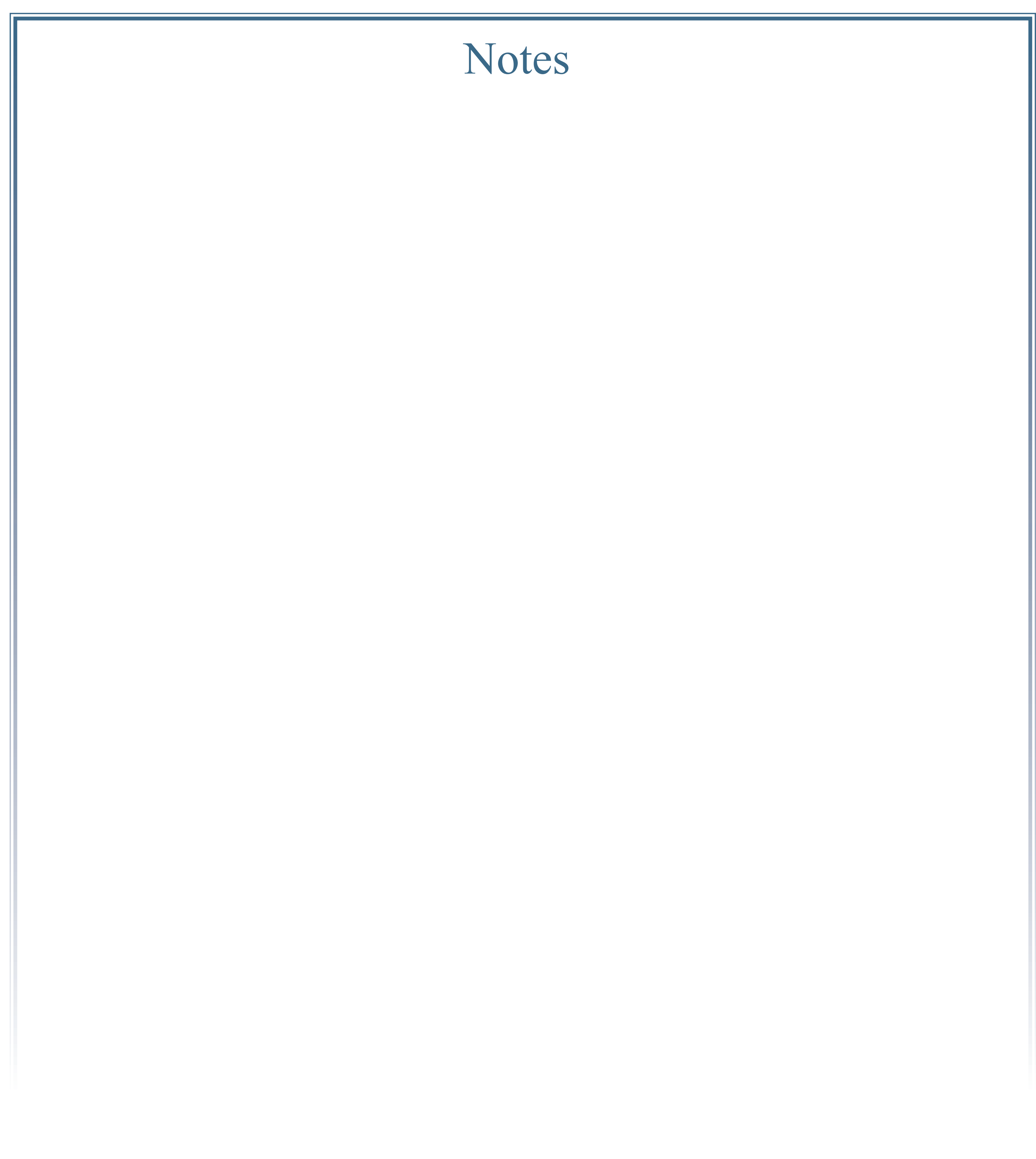
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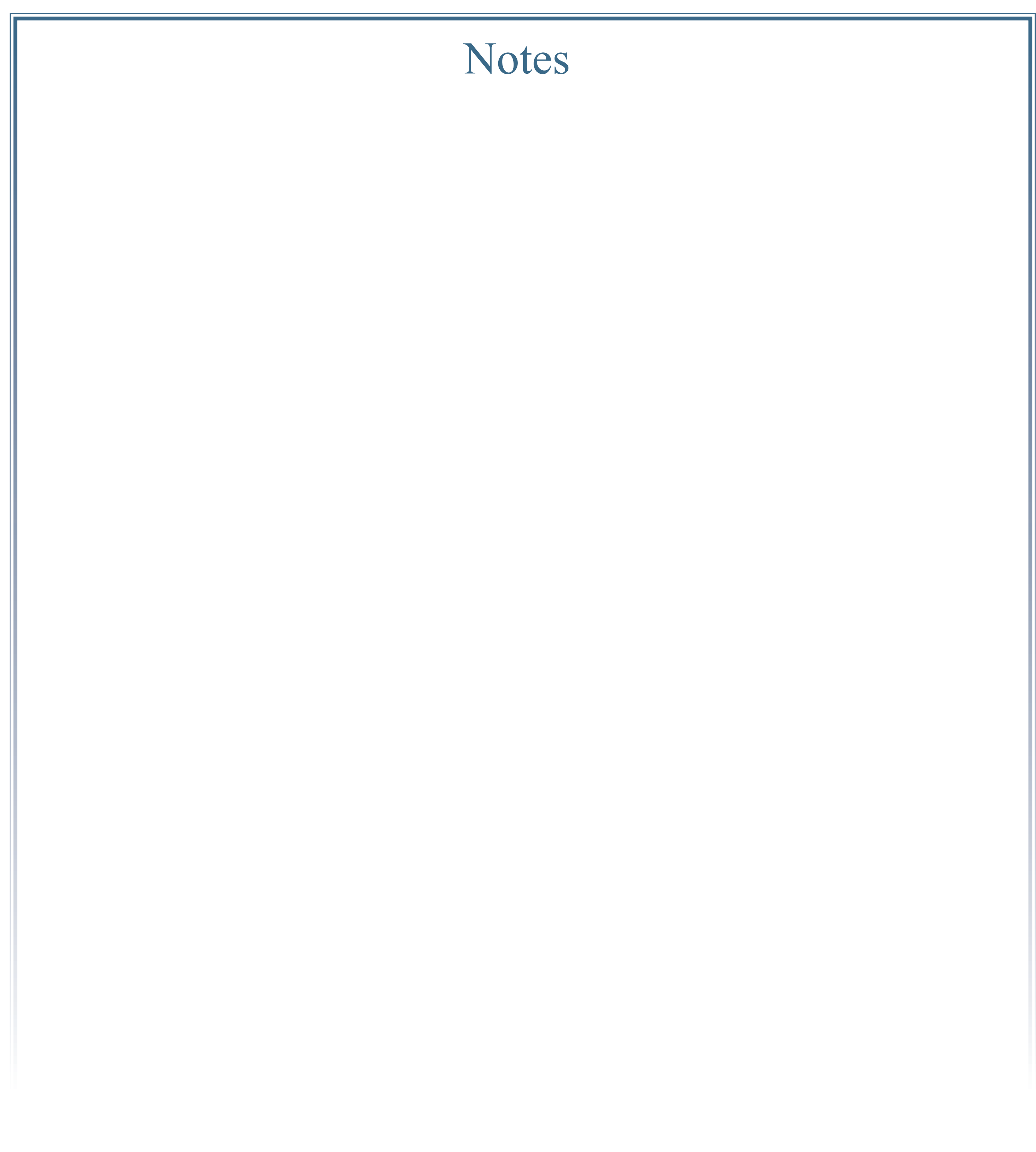
Reference E
Other Useful Websites

The following websites and contact information may be useful to providers interested in further information on preventive services and certain diseases and conditions mentioned throughout this Guide.

Resource	Website
Advisory Committee on Immunization Practices (ACIP)	http://www.cdc.gov/vaccines/recs/acip
Agency for Healthcare Research and Quality (AHRQ)	http://www.ahrq.gov
AIDS.gov	http://aids.gov
AIDSInfo.gov	http://www.aidsinfo.nih.gov
American Academy of Ophthalmology (AAO)	http://www.aao.org
American Association of Diabetes Educators	http://www.diabeteseducator.org/ProfessionalResources/accred
American Cancer Society (ACS)	http://www.cancer.org
American Cancer Society's Cancer Facts and Figures	http://www.cancer.org/Research/CancerFactsFigures/index?ssSourceSiteId=null
American Diabetes Association (ADA)	http://www.diabetes.org
American Dietetic Association	http://www.eatright.org
American Heart Association	http://www.heart.org/HEARTORG
American Lung Association	http://www.lungusa.org
American Lung Association Flu Clinic Locator	http://www.lungusa.org/lung-disease/influenza/flu-vaccine-finder
American Thoracic Society (ATS)	http://www.thoracic.org
Association for Prevention Teaching and Research	http://www.atpm.org
Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov
CDC National Center for Chronic Disease Prevention and Health Promotion	http://www.cdc.gov/chronicdisease
CDC: Vaccines & Immunizations	http://www.cdc.gov/vaccines

Resource	Website
Department of Health and Human Services (HHS)	http://www.hhs.gov
Everyday Choices	http://www.everydaychoices.org
Eye Care America	http://www.eyecareamerica.org
The Glaucoma Foundation	http://www.glaucomafoundation.org
Healthfinder.gov	http://www.healthfinder.gov
Immunization Action Coalition (IAC)	http://www.immunize.org
Infectious Diseases Society of America (IDSA)	http://www.idsociety.org
Level I Current Procedural Terminology (CPT) Book Level II Healthcare Common Procedure Coding System (HCPCS) Book ICD-9-CM Diagnosis Coding Book	Order online by visiting the American Medical Association Press Online Catalog at https://catalog.ama-assn.org/Catalog/home.jsp on the Internet. Toll-Free: 800-621-8335
List of Claims Adjustment Reason and Remark Codes	http://www.wpc-edi.com/Codes
Medicare Quality Improvement Community (MedQIC)	http://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQPage/Homepage
MedlinePlus Health Information	http://www.nlm.nih.gov/medlineplus
National Alliance for Hispanic Health	http://www.hispanichealth.org
National Cancer Institute (NCI)	http://www.cancer.gov
National Center for Immunization and Respiratory Diseases (NCIRD)	http://www.cdc.gov/ncird
National Diabetes Education Program	http://www.ndep.nih.gov
National Diabetes Information Clearinghouse (NDIC)	http://diabetes.niddk.nih.gov
National Eye Institute (NEI)	http://www.nei.nih.gov
National Foundation for Infectious Diseases (NFID)	http://www.nfid.org

Resource	Website
National Heart, Lung, and Blood Institute (NHLBI)	http://www.nhlbi.nih.gov
National Institutes of Health	http://www.nih.gov
National Kidney and Urologic Diseases Information Clearinghouse	http://kidney.niddk.nih.gov
National Kidney Disease Education Program	http://nkdep.nih.gov
National Network for Immunization Information (NNII)	http://www.immunizationinfo.org
National Osteoporosis Foundation	http://www.nof.org
National Vaccine Program Office	http://www.hhs.gov/nvpo
Office of the U.S. Surgeon General Tobacco Cessation Guidelines	http://www.surgeongeneral.gov/tobacco
Osteoporosis and Related Bone Diseases National Resource Center	http://www.niams.nih.gov/Health_Info/Bone
Partnership for Prevention	http://www.prevent.org
Prevent Blindness America	http://www.preventblindness.org
Smokefree.gov	http://www.smokefree.gov
Social Security Administration	http://www.socialsecurity.gov
Society for Vascular Surgery	http://www.vascularweb.org
Society of Thoracic Surgeons	http://www.sts.org
U.S. Administration on Aging	http://www.aoa.gov
U.S. Preventive Services Task Force (USPSTF)	http://www.uspreventiveservicestaskforce.org
USPSTF Guide to Clinical Preventive Services	http://www.uspreventiveservicestaskforce.org/recommendations.htm
Washington Publishing Company (WPC)	http://www.wpc-edi.com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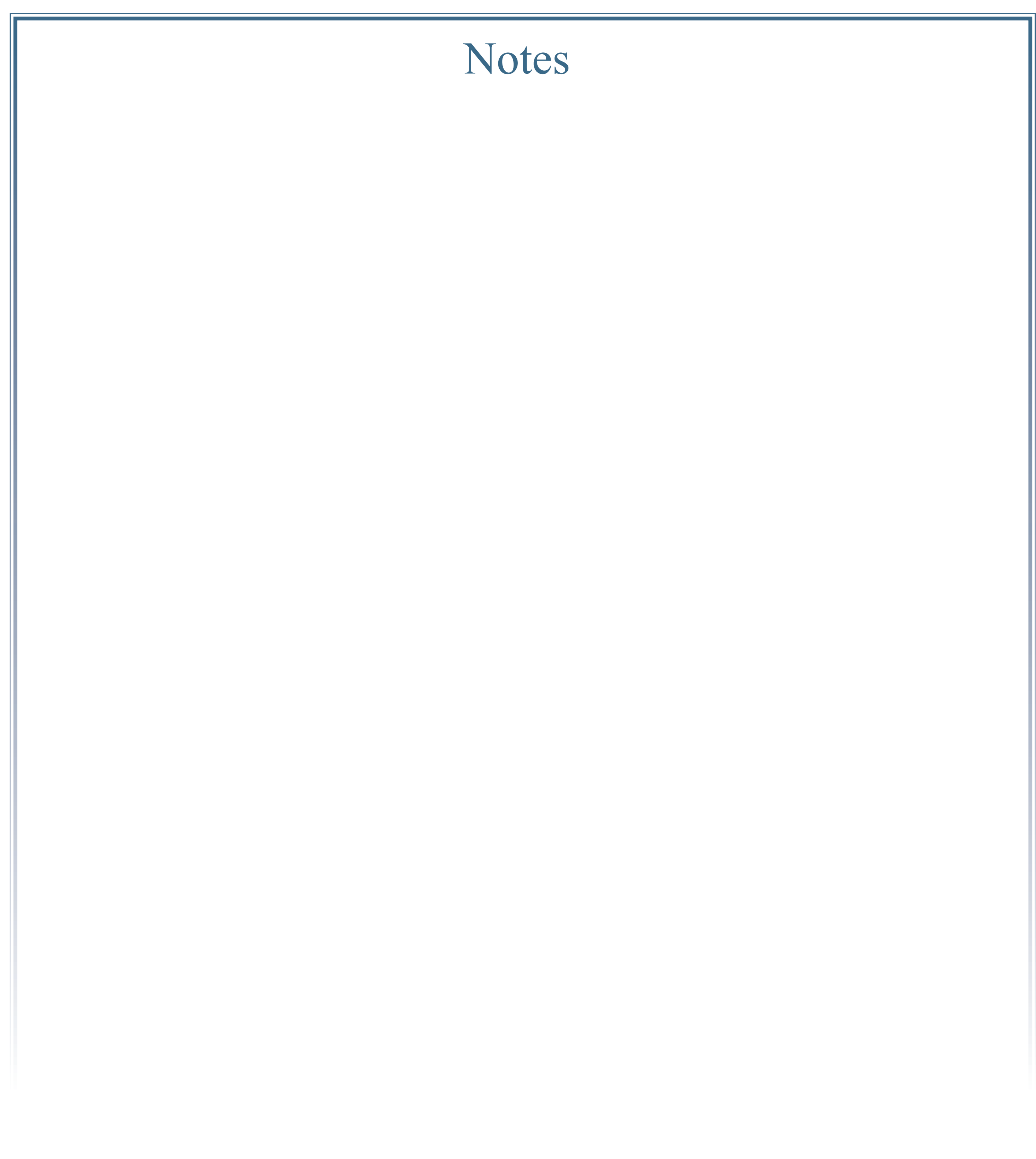
Reference F
Resources for Medicare Beneficiaries

The following websites and contact information may be useful to beneficiaries interested in further information on Medicare benefits and services.

Resource	Website/Contact Information
Medicare Beneficiary Publications	This site allows beneficiaries to search for publications that contain helpful information about Medicare benefits. http://www.medicare.gov/Publications/Search/SearchCriteria.asp?version=default&browser=IE%7C6%7CWinXP&Language=English&pagelist=Home&comingFrom=13
Manage Your Health – Preventive Services	http://www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-overview.aspx
Medicare Beneficiary Help Line and Website	To obtain general Medicare information, order Medicare publications, get health plan information, and much more, beneficiaries can visit http://www.medicare.gov on the Internet, or they can call 1-800-MEDICARE 24 hours a day, 7 days a week for assistance. Telephone: Toll-Free: 1-800-MEDICARE (1-800-633-4227) TTY Toll-Free: 1-877-486-2048 Website: http://www.medicare.gov
"Medicare & You" Publication	http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf
Medicare Prescription Drug Coverage	Includes basic information about Medicare prescription drug coverage, drug plan finder, formulary (drug) finder, and enrollment center. http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx
MyMedicare.gov	This website is a one-stop, user-friendly website that gives registered Medicare beneficiaries access to personalized information on benefits and services that are available to them. http://www.mymedicare.gov
Social Security Administration	http://www.ssa.gov
State Health Insurance Assistance Program (SHIP)	This website provides contact information for State SHIP offices. Local SHIPs provide health insurance counseling and information to Medicare beneficiaries through free personalized, face-to-face counseling and assistance via telephone, public education presentations and programs, and media activities. http://www.medicare.gov/Contacts
U.S. Administration on Aging	http://www.aoa.gov



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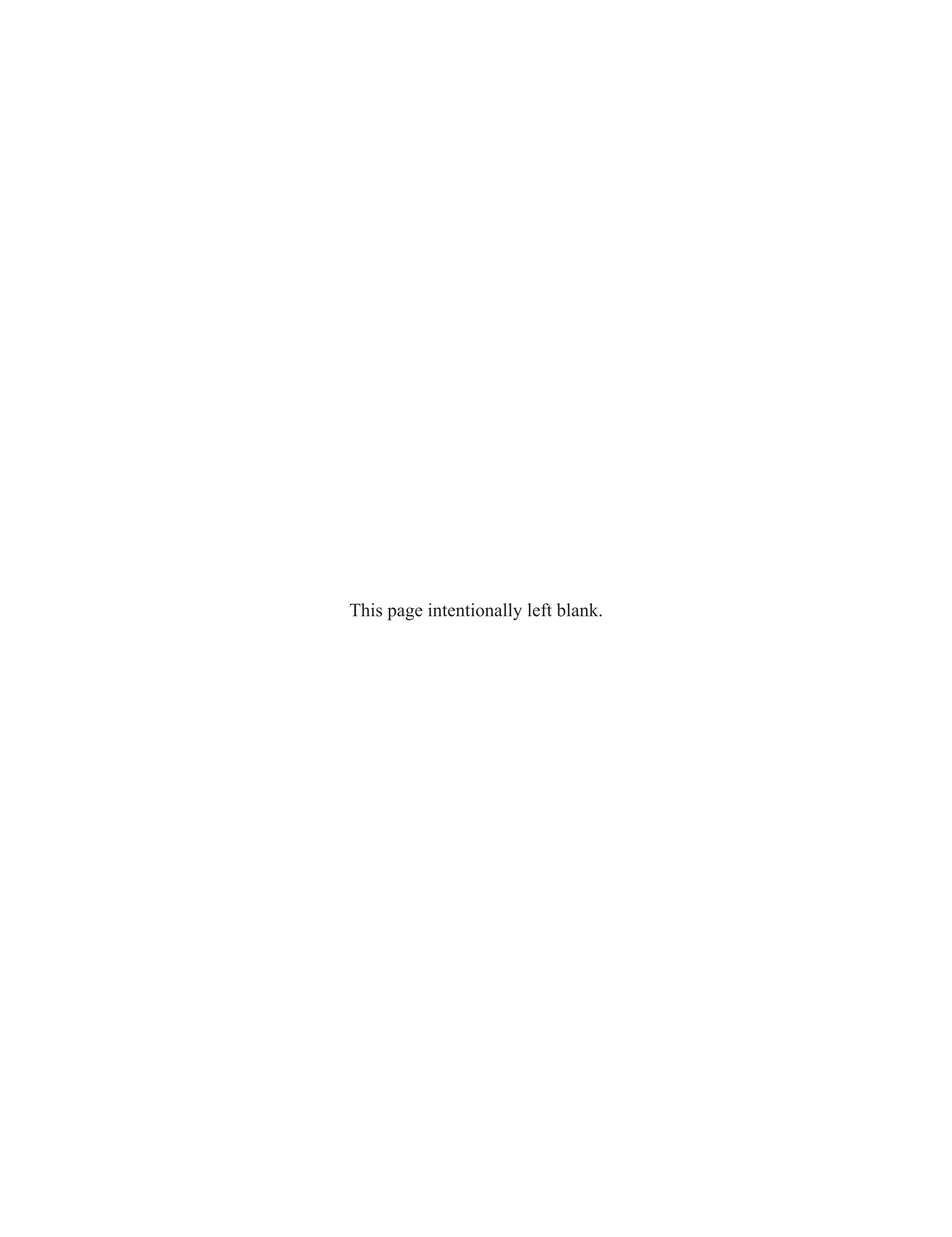

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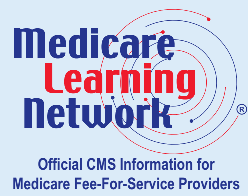

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