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PART B



Preventive Services Billing Guide

July 2010

NHIC, Corp.

Preventive Services Billing Guide

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Preventive Services Billing Guide

INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Preventive Services billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the CMS, are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-04 Chapter 18 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.gov/manuals/>

If you have questions or comments regarding this material, please call the Customer Service Center at 866-801-5304.

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GENERAL INFORMATION

Medicare pays for reasonable and necessary services for the diagnosis and treatment of an illness or injury. Although the law generally precludes payment for preventive services, Congress has specifically legislated coverage for certain preventive services.

Medicare covers preventive health services in order to keep beneficiaries healthy. These services are provided based on age, gender, and medical history. If results of any of the screening examinations indicate that further tests are needed, the additional tests would be considered diagnostic.

The following preventive services are covered:

- Bone Mass Measurement
- Cardiovascular Screening
- Colorectal Cancer Screening
- Diabetes Screening
- Flu (Influenza) Injections
- Glaucoma Screening
- Hepatitis B Injections
- Initial Preventive Physical Examination
- Mammography Screening
- Medical Nutrition Therapy
- Pneumococcal Pneumonia Vaccination (PPV)
- Prostate Cancer Screening
- Screening Pap Smears
- Screening Pelvic Examinations
- Smoking and Tobacco-Use Cessation
- Ultrasound Screening for Abdominal Aortic Aneurysm

The following sections will provide details regarding each of these services, including coverage requirements, procedure codes, diagnosis criteria, and reimbursement policies. For more specific billing requirements relating to the CMS-1500 claim form or electronic equivalents, refer to the **1500 Claim Form Instructions** in the Publication section of our website at: <http://www.medicarenhic.com>. Additional billing guides are also available.

General Reimbursement Policy

Medicare generally pays 80% of the approved amount based on the physician's fee schedule amount or 100% of the clinical lab fee schedule amount for preventive services. Deductible and coinsurance may apply to some services. The deductible for 2007 is \$131.

Billing Tips

The same tests and services used for prevention are commonly performed for diagnostic purposes. Many of the tests or services performed for preventive purposes (i.e., to screen for the

presence of an illness, or injury without apparent signs or symptoms) have been assigned a HCPCS Level II procedure code. When the same test or service is performed for a diagnostic or treatment purpose (i.e., to evaluate a sign, symptom, known illness, or injury) a CPT code is used.

An ICD-9-CM code must reference a specific procedure code on the claim. The choice of ICD-9-CM code is governed by whether the service is performed for a preventive or a diagnostic purpose. The ICD-9-CM code for a preventive service generally describes a reason for the medical encounter, i.e. family history, and not a symptom or illness. Typically these are referred to as “V” codes. The ICD-9-CM codes for diagnostic services describe an illness or symptom.

BONE MASS MEASUREMENT

The Bone Mass Measurement test can identify bone mass, detect bone loss, or determine bone quality. Testing devices include a bone densitometer, a bone sonometer, and computerized tomography. This procedure includes a physician’s interpretation of the test results. According to the consensus of the medical community, bone mass measurement studies are the most objective risk indicators for fractures and/or osteoporosis. Although this is not technically a preventive service, Section 4106 of the Balanced Budget Act (BBA) of 1997 standardized coverage of bone measurements as a screening service.

Procedure Codes and Descriptors

The following HCPCS codes should be used for reporting bone mass measurements:

- G0130 Single energy x-ray absorptiometry (SEXA) bone density, one ore more sites appendicular skeleton peripheral (i.e., radius, wrist, heel);
- 77078* Computed tomography bone mineral density study, one or more sites, axial skeleton (e.g., hips, pelvis, spine);
- 77079* Computed tomography, bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist heel);
- 77080* Dual-energy x-ray absorptiometry (DXA) bone density study, one ore more sites: axial skeleton (e.g., hips, pelvis, spine);
- 77081* 77081 Dual-energy x-ray absorpitometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel);
- 77083* Radiographic absorptiometry (DXA), bone density study, one or more sites;
- 76977 Ultrasound bone mineral density measurement and interpretation, peripheral site(s), any method.

No payment is allowed for procedure code 78350 (bone density (bone mineral content) study, one or more sites; single photon absorptiometry). *This is a non covered service.*

NOTE: *New codes effective for dates of service on or after January 1, 2007. For dates of service 2006 and prior, refer to 76070-76077.

Diagnosis Criteria

CMS has provided coverage for individuals at risk for osteoporosis. The procedure must be performed on a qualified individual for the purpose of measuring bone mass, detecting bone loss, or determining bone quality. A qualified individual is an individual who meets the medical indications for at least one of the following categories:

- A woman who, based on medical history and other findings, has been determined to be estrogen deficient as defined by her physician and is at clinical risk for osteoporosis.
- An individual (male or female) with vertebral abnormalities, osteoporosis, osteopenia, or vertebral fracture demonstrated by an x-ray;
- An individual (male or female) with primary hyperparathyroidism;
- An individual (male or female) being monitored to assess the response to or efficacy of an FDA-approved Osteoporosis drug therapy; or
- An individual (male or female) receiving or expecting to receive glucocorticoid (steroid) *therapy equivalent to 5.0 mg of prednisone*, or greater per day for more than three months.

NOTE: *Effective for dates of service on or after January 1, 2007. For dates of service 2006 and prior, equivalent is 7.5 mg of prednisone, or greater per day, for more than three months.

Monitoring Osteoporosis Drug Therapy

Bone Mass Measurement services provided to monitor Osteoporosis Drug Therapy are covered when billed with CPT code 77080 (Dual-energy x-ray absorptimetry (DXA) bone density study, one or more sites: axial skeleton (e.g., hips pelvis, spine)). All other procedure codes billed to monitor Osteoporosis Drug Therapy are non-covered.

Medicare allows payment when these services are billed with the following ICD-9-CM codes; however any ICD-9-CM code may be used when it is appropriate for bone mass measurement to monitor osteoporosis drug therapy. Medicare may request medical record documentation to verify the diagnosis requirements are met for osteoporosis drug therapy.

Diagnosis Criteria

733.00 Osteoporosis

733.01 Senile Osteoporosis

- 733.02 Idiopathic osteoporosis
- 733.03 Disuse Osteoporosis
- 733.09 Other (drug induced osteoporosis)
- 733.90 Disorder of bone and cartilage, unspecified
- 255.0 Cushing's syndrome

Medicare will not cover other bone mass measurement CPT codes billed with the ICD-9-CM codes listed above.

Advanced Beneficiary Notice (ABN) Requirements

A physician should obtain an Advanced Beneficiary Notice (ABN) when services provided fall outside of Medicare coverage requirements. The ABN can be found on the CMS website at: <http://www.cms.gov/cmsforms/downloads/cmsr-131-g.pdf>.

Physicians, practitioners and hospitals will be liable for Bone Mass Measurement services unless they issue an appropriate Advanced Beneficiary Notice. Physicians and hospitals should use the following language when completing an ABN for Bone Mass Measurement Services:

“Item or Service” section:

Insert the name of the denied procedure

“Because” section:

“As specified in chapter 15, section 80.5 of Pub. 100-2, Medicare Benefit Policy Manual, Medicare will not pay for this test as it is not reasonable and necessary for Medicare beneficiaries undergoing bone mass measurement.”

*For more information visit the IOM on the CMS website at: <http://www.cms.gov/manuals>
(CMS Reference: Pub 100-04 Chapter 13 Section 140)*

CARDIOVASCULAR SCREENING

Effective January 1, 2005, the Medicare Modernization Act expanded coverage to include the following cardiovascular screening blood tests: total cholesterol, high density lipoprotein, and triglycerides. These tests should be performed as a panel and only following a 12-hour fast. Medicare covers these tests at a frequency of once every five years (at least 59 months after the last covered screening test). The services must be ordered by a physician or qualified non-physician practitioner.

Procedure Codes and Descriptors

- 80061 Lipid Panel
- 82465 Cholesterol, serum or whole blood, total

83718 Lipoprotein, direct measurement; high density cholesterol, HDL Cholesterol
84478 Triglycerides

The tests are performed as a panel; however, they are also available as individual tests. Medicare pays for these tests under the clinical laboratory fee schedule. No deductible or coinsurance apply.

Diagnosis Criteria

When these tests are performed for screening purposes, the beneficiary should not show any apparent signs or symptoms.

The following screening diagnosis codes are valid when billing for the cardiovascular screening tests:

V81.0 Special screening for ischemic heart disease

V81.1 Special screening for hypertension

V81.2 Special screening for other and unspecified cardiovascular conditions

NOTE: The screening diagnosis code **must be referenced** when billing for these cardiovascular screening tests because these CPT codes are subject to other local and/or national coverage determinations. Pointing to the screening diagnosis code allows the claim to bypass these edits.

For more information visit the IOM on the CMS website at: <http://www.cms.gov/manuals>
(CMS Reference: Pub 100-04 Chapter 18 Section 100)

COLORECTAL CANCER SCREENING

Medicare coverage of various colorectal cancer screening procedures was implemented as a result of the Balanced Budget Act (BBA) of 1997. Colorectal cancer screening examinations are subject to certain frequency and payment limitations. Medicare covers the following colorectal cancer screening services: fecal-occult blood test, flexible sigmoidoscopy, colonoscopy, and barium enema.

Screening Fecal Occult Blood Test

Screening Fecal-Occult Blood Test is a guaiac-based (gFOBT) test for peroxidase activity. The beneficiary completes the test by taking samples from two different sites of three consecutive stools. Medicare covers these tests at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done);

- For beneficiaries who have attained the age 50; and/or
- With a written order from the beneficiary's attending physician.

Fecal occult blood tests are paid under the clinical lab fee schedule. The deductible and coinsurance do not apply for this test. For dates of service 2007 and after, the code is:

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 3 cards or a single triple card for consecutive collection))

For dates of service prior to 2007, use G0107.

NOTE: The term “attending physician” is defined as a doctor of medicine or osteopathy as defined in XVIII of the Social Security Act §1861(r)(1) 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.

Do not bill procedure code 82270 on three different lines or for three consecutive days. This procedure code should be reported only once. The reimbursement for this code reflects that the test was done on three different days. Report the date the test was actually performed on the patient’s sample, not the date the card(s) was issued to the patient or when the patient returned the card(s) to the office. An immunoassay screening fecal occult blood test G0328, can be used as an alternative to 82270.

G0328 colorectal screening, fecal occult blood test, immunoassay 1-3 simultaneous determinations

Medicare patients ages 50 and over can only receive one FOBT per year, either 82270 (gFOBT, or guaiac based) or G0328 (iFOBT, or immunoassay-based), but not both.

For more information, visit the IOM on the CMS website at: <http://www.cms.gov/manuals>
(CMS Reference: Pub. 100-02 Chapter 15 Section 280.2.1)

Screening Flexible Sigmoidoscopy

A screening flexible sigmoidoscopy (G0104) is covered for beneficiaries age 50 and up when the test is performed by a physician or qualified non-physician practitioner. The test is covered at a frequency of once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was done).

Screening Colonoscopy

Screening colonoscopies (G0105) may be paid when performed by a doctor of medicine or osteopathy. High risk beneficiaries are eligible for this service.

The following circumstances indicate that a patient meets the high risk criteria:

- A close relative (sibling, parent, or child) who has had colon cancer or adenomatous polyposis)

- A family history of familial adenomatous polyposis
- A family history of hereditary nonpolyposis colon cancer
- A personal history of adenomatous polyps
- A personal history of colon cancer
- Inflammatory bowel disease, including Crohn's Disease and ulcerative colitis

Medicare covers this procedure at a frequency of once every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening was done).

Screening Colonoscopies Performed on Individuals Not Meeting the High-Risk criteria for Developing Colorectal Cancer

Medicare pays for screening colonoscopies (G0121) performed under the following conditions:

- Once every 10 years (i.e., at least 119 months have passed following the month in which the last covered screening colonoscopy (G0121) was performed).
- If the individual would otherwise qualify for a screening colonoscopy based on the above, but has had a covered screening flexible sigmoidoscopy (G0104), then he or she may have covered a screening colonoscopy only after at least 47 months have passed following the month in which the last covered flexible sigmoidoscopy was performed.

NOTE: If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure, classified as a colonoscopy with biopsy or removal, should be billed rather than code G0121.

Screening Barium Enema

Screening barium enema examinations may be paid as an alternative to either a screening sigmoidoscopy or a screening colonoscopy (G0106 or G0120). Medicare covers this procedure based on beneficiary risk:

For Beneficiaries at High Risk for Developing Colorectal Cancer

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

For Beneficiaries Not at High Risk for Developing Colorectal Cancer

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

The screening barium enema must be ordered in writing if it is deemed the most appropriate screening test.

Procedure Codes and Descriptors

The following codes have been established for colorectal cancer screening services:

- G0104** Colorectal cancer screening; flexible sigmoidoscopy
- G0105** Colorectal cancer screening; colonoscopy on individual at high risk
- G0106** Colorectal cancer screening; barium enema; as an alternative to G0104
- G0107*** Colorectal cancer screening; fecal occult blood test, 1-3 simultaneous determinations
- G0120** Colorectal cancer screening; barium enema: as an alternative to G0105
- G0121** Colorectal cancer screening colonoscopy on individual not meeting criteria for high risk
- G0328** Colorectal cancer screening; immunoassay, fecal-occult blood test, 1-3 simultaneous determinations
- 82270*** Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations

*As of January 1, 2007 and later, physicians shall report CPT code 82270 in place of HCPCS code G0107 when billing for screening fecal occult blood test, 1-3 simultaneous determinations. For claims with dates of service December 31, 2006 and earlier, HCPCS code G0107 should be used. Deductible and coinsurance do not apply.

Diagnosis Criteria

When these tests are performed for screening purposes, the beneficiary does not have to show any signs or symptoms. However, when billing for a high-risk patient, the appropriate high risk ICD-9-CM diagnosis code should be indicated on the claim. Listed below are some examples of diagnoses that meet high-risk criteria for colon cancer screening. Other conditions may be covered based on medical review.

Personal History of malignant neoplasm of rectum, rectosigmoid junction

- V10.05** Personal history of malignant neoplasm of large intestine
- V10.06** Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

Chronic Digestive Disease Condition

- 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

Inflammatory Bowel

558.2 Toxic gastroenteritis and colitis

558.9 Other and unspecified non-infectious gastroenteritis and colitis

Reimbursement Policy

Medicare pays 80% of the approved amount based on the physician's fee schedule amount for all the colonoscopy cancer screening services except the fecal occult tests. 100% of the clinical lab fee schedule is paid on screening fecal occult tests. Coinsurance applies for all services except the fecal occult blood tests.

For services performed in an Ambulatory Surgical Center (ASC) on or after January 1, 2007, the Medicare beneficiary is responsible for a 25% coinsurance amount for the ASC facility payment.

Effective January 1, 2007, Medicare will waive the annual Medicare Part B deductible for colorectal cancer screening test (HCPCS codes: G0104, G0105, G0106, G0120, and G0121) services furnished on or after January 1, 2007.

Reference: MLN Matters #MM5127

Non-Covered Colon Screening Services

The reporting of non-covered services using code G0122 will allow the claim to deny for beneficiaries who need a Medicare denial for other insurance purposes. Code G0122 (colon cancer screening; barium enema) should be used when a screening barium enema is performed, **not** as an alternative to either a screening colonoscopy (code G0105) or a screening flexible sigmoidoscopy (code G0104). This service is denied as non-covered because it fails to meet the requirements of the benefit. As a result the beneficiary is liable for payment.

Note: When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. When 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. When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with a modifier 53 to indicate that the procedure was interrupted.

For more information visit the IOM on the CMS website at: www.cms.gov/manuals (CMS Reference: Pub 100-04 Chapter 18 Section 60)

DIABETES SCREENING

Medicare permits coverage for the following diabetes screening tests for services performed on or after Jan. 1, 2005 for individuals who satisfy the high risk criteria for diabetes:

- Fasting plasma glucose test.
- Post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults or a two-hour post-glucose challenge test alone).

Background Information

This coverage is mandated by Section 613 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

An individual with **one (1) of the following individual risk factors for diabetes is eligible** for this new benefit:

- Hypertension
- Dyslipidemia
- Obesity (with a body mass index greater than or equal to 30 kg/m²)
- Previous identification of elevated impaired fasting glucose or glucose intolerance.

Or an individual with any **two (2) of the following risk factors for diabetes is also eligible** for this new benefit:

- Overweight (a body mass index greater than 25 but less than 30 kg/m²).
- A family history of diabetes.
- Age 65 years or older.

Coverage will be provided for one screening test every six months for individuals diagnosed with pre-diabetes (defined below), and one screening test within a 12-month period for individuals who were not diagnosed with pre-diabetes or who have never been tested. This coverage does not apply to individuals previously diagnosed as diabetic. These tests are payable under the clinical lab fee schedule and deductible and coinsurance do not apply.

Procedure Codes and Descriptors

82947 Assay, glucose, blood quant

82950 Glucose test

82951 Glucose tolerance test (gtt)

Diagnosis Criteria

Use ICD-9-CM code **V77.1** when billing for these tests, and point to this screening diagnosis in order to bypass other LCD or NCD edits.

Note: use modifier “TS” (follow up services) to indicate that the test was performed on an individual diagnosed with pre-diabetes. Pre diabetes is defined as follows: abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to 125 mg/dL, or a 2-hour post-glucose challenge of 140 to 199 mg/dL. The term “pre-diabetes” includes impaired fasting glucose and impaired glucose tolerance.

For more information visit the IOM on the CMS website at: <http://www.cms.gov/manuals>
(CMS Reference: Pub 100-04 Chapter 18 Section 90)

FLU (INFLUENZA) INJECTIONS

Medicare pays for the flu vaccine injection along with its administration once per flu season.

Procedure Codes and Descriptors

Procedure codes for the flu vaccine injection:

- 90655 Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
- 90656 Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
- 90657 Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
- 90658 Influenza virus vaccine, split virus, for use in individuals 3 years and above, for intramuscular use
- 90660 ** Influenza virus vaccine, live, for intranasal use
- G0008 Administration of influenza virus vaccine

**As of October 2, 2006, Medicare will accept claims containing current procedural terminology (CPT) code 90660 for the influenza virus vaccine, live, intranasal use.

Mandatory assignment applies to all drugs and biologicals. For administration code G0008, mandatory assignment does not apply. Non-participating physicians may bill the administration as non-assigned.

Diagnosis Criteria

Use ICD-9-CM, **V04.81** for the influenza virus vaccine and administration.

As of October 2, 2006, providers may report diagnosis code V06.6 on claims for PPV and/or Influenza Virus vaccines when the purpose of the visit was to receive both vaccines.

V06.6 PPV and Influenza

Reimbursement Policy

Medicare pays 100% of the Medicare approved amount. The annual deductible and coinsurance do not apply. Therefore, if a beneficiary receives an influenza vaccination from a physician, provider, or supplier who agrees to accept assignment (i.e., agrees to accept Medicare payment as payment in full), there is no cost to the beneficiary. If a beneficiary receives an influenza vaccination from a physician, provider, or supplier who does not accept assignment, the physician may collect his or her usual charge for the *administration* of the vaccine but may not collect any fee up front for the *vaccine* and must accept the Medicare-approved amount. The flu vaccine is subject to mandatory assignment regardless of whether the physician normally does not accept assignment.

For more information visit the IOM on the CMS website at www.cms.gov/manuals
(CMS Reference: Pub 100-04 Chapter 18 Section 10)

GLAUCOMA SCREENING

The Benefits Improvements and Protection Act (BIPA) of 2000 provide annual coverage for glaucoma screening for eligible Medicare beneficiaries in the following high risk categories:

- (1) Individuals with diabetes mellitus,
- (2) Individuals with a family history of glaucoma, or
- (3) African-Americans age 50 and over, when rendered by or under the direct supervision in the office setting of an ophthalmologist or optometrist, who is legally authorized to perform the services under state law.

As of January 1, 2006, Glaucoma Screening (42 CFR 410.23 (a) (2) revised), has been expanded to include:

- (4) Hispanic American age 65 and over, considered to be at high-risk.

Screening for glaucoma is defined to include:

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

Medicare will pay for a glaucoma screening examination performed on an eligible beneficiary annually when at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed.

Procedure Codes and Descriptors

Use the following HCPCS codes to bill for glaucoma screening:

- 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 Criteria

V80.1 Glaucoma

Reimbursement Policy

Medicare pays 80% of the approved amount based on the physician's fee schedule amount for the service, or the submitted charge, whichever is lower. Deductible and coinsurance apply to these services.

For more information visit the IOM on the CMS website at www.cms.gov/manuals
(CMS Reference: Pub 100-04 Chapter 18 Section 70)

HEPATITIS B INJECTIONS

With the enactment of P.L. 98-369, coverage under Part B was extended to hepatitis B vaccine and its administration furnished to a Medicare beneficiaries at high or intermediate risk of contracting hepatitis. High risk groups are:

- End stage renal disease (ESRD) patients
- Hemophiliacs who receive Factor VIII or IX concentrates
- Clients of institutions for the mentally handicapped
- Persons who live in the same household as an Hepatitis B Virus (HBV) carrier
- Homosexual men
- Illicit injectable drug users

Intermediate risk groups are:

- Staff in institutions for the mentally handicapped
- Workers in health care profession who have frequent contact with blood or blood derived body fluids during routine work

Procedure Codes and Descriptors

90740	Hepatitis B vaccine, dialysis or immunosuppressed patient (3 dose schedule), for intramuscular use
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744	Hepatitis B vaccine pediatric or 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 dose (4 dose schedule), for intramuscular use
G0010	Administration of hepatitis B vaccine when no physician fee schedule service is

provided on the same day

Mandatory assignment applies to all drugs and biologicals. For administration code G0010, mandatory assignment does not apply. Non-participating physicians may bill the administration as non-assigned.

Diagnosis Criteria

V05.3 Viral hepatitis

Reimbursement Policy

Medicare pays 80% of the Medicare allowed amount. Deductible and coinsurance apply to these services. The 5% differential between participating and non-participating providers applies.

For more information visit the IOM on the CMS website at www.cms.gov/manuals (CMS Reference: Pub 100-04 Chapter 18 Section 10)

INITIAL PREVENTIVE PHYSICAL EXAMINATION

The Medicare Modernization Act of 2003 provides coverage of an initial preventive physical exam (IPPE) or “Welcome to Medicare” Physical for new beneficiaries who have service dates on or after January 1, 2005. Prior to January 1, 2009, the physical must be performed no later than **6** months after the individual’s effective date with Medicare Part B, but only if that coverage begins on or after January 1, 2005. Effective January 1, 2009, the physical must be performed no later than **12** months after the individual’s effective date with Medicare Part B. The examination may be performed by a physician or a qualified non-physician practitioner.

The IPPE includes the following components:

- Measurement of height, weight, blood pressure, and visual acuity
- Performance and interpretation of a screening electrocardiogram (must be billed on claim) (effective on and after January 1, 2009, this is no longer mandatory)
- Review of the individual’s medical and social history
- Review of the individual’s potential risk factors for depression, functional ability and level of safety with the goal of health promotion and disease detection
- Education, counseling, and referral with respect to screening and preventive services currently covered under Medicare Part B
- Measurement of body mass index (effective on and after January 1, 2009)
- End of life planning upon the individual’s consent (effective on and after January 1, 2009)

Procedure Codes and Descriptors

Effective for dates of service January 1, 2005 through December 31, 2008

Preventive Services Billing Guide

G0344 Initial Preventive Physical Examination (IPPE); face-to-face visit, services limited to new beneficiary during the first six months of Medicare Part B enrollment

As required by statute, the IPPE benefit **always** includes a screening EKG, which should be billed using one of the following HCPCS codes:

G0366 Full EKG service (tracing, interpretation, and report)

G0367 EKG technical component only (tracing)

G0368 EKG professional component only (interpretation and report)

Effective for dates of service on and after January 1, 2009

G0402 Initial Preventive Physical Examination (IPPE); face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare Part B enrollment

Effective on and after January 1, 2009, the screening EKG is no longer mandated. There must be education, counseling, and referral for an EKG. This is a once in a lifetime EKG as a result of a referral from an IPPE.

G0403 Full EKG service (tracing, interpretation, and report)

G0404 EKG technical component only (tracing)

G0405 EKG professional component only (interpretation and report)

If the primary physician or qualified NPP does not perform the EKG during the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring provider needs to ensure that the performing provider bills the appropriate G code, and not a CPT code in the 93000 series.

No diagnosis requirement is in place for the IPPE; use an appropriate screening diagnosis. V700 (Routine medical examination at a health care facility) is acceptable.

Payment will not include the lab tests. Prior to January 1, 2009, payment for the IPPE would be applied to the annual deductible if the deductible has not been met, with the exception of Federally Qualified Health Centers (FQHCs). Effective January 1, 2009, the annual deductible will **not** be applied. The usual coinsurance provisions apply for all dates.

While some components of a medically necessary evaluation and management (E/M) service will be reflected in HCPCS code G0344 and G0402, Medicare will, when it is clinically appropriate, allow payment for a medically necessary E/M service at the same visit as the IPPE. That portion of the visit must be medically necessary to treat the patient's illness or injury or to improve the functioning of a malformed body member and shall be reported with modifier 25.

The physician, qualified NPP, or hospital may also bill for the screening and other preventive services currently covered and paid by Medicare Part B under separate provisions of section 1861 of the Social Security Act, if provided during the IPPE.

For more information visit the IOM on the CMS website at: <http://www.cms.gov/manuals>
(CMS Reference: Pub 100-04 Chapter 18 Section 80)

MAMMOGRAPHY SCREENING

The term screening mammography is defined as a “radiological procedure for early detection of breast cancer.” The test includes a physician’s interpretation of the results. In screening mammography, the patient typically has not manifested any clinical signs, symptoms, or physical findings of breast cancer. The screening mammogram is performed to detect the presence of a breast abnormality in its incipient stage and to serve as a baseline to which future screening or diagnostic mammograms may be compared.

Certification Requirements

The Mammography Quality Standards Act (MQSA) requires all facilities providing mammogram services (both screening and diagnostic) to meet national quality standards in order to operate. Facilities providing mammogram services must be certified by the Food and Drug Administration (FDA) and be able to provide the six digit certification number issued by the FDA in item 32 of the CMS-1500 claim form or the electronic equivalent. Claims submitted without a valid certification number will be denied.

- If a film mammography HCPCS code is on a claim and the facility is certified for digital mammography only, the claim is denied.
- When a digital mammography HCPCS code is on a claim, the claim is checked for a digital indicator.
- If a digital mammography HCPCS code is on a claim and the facility is certified for digital mammography, the claim is paid if all other relevant Medicare criteria are met.
- If a digital mammography HCPCS code is on a claim and the facility is certified for film mammography only, the claim is denied.

Coverage Requirements

A physician’s prescription or referral is not required for coverage of a screening mammogram. Medicare coverage guidelines for mammograms, revised as a result of legislation included in the Balanced Budget Act (BBA) of 1997, provide for:

- A baseline mammogram for women 35-39 (only one allowed for this age group)
- Annual screening mammograms for women over age 39. To count for the next “annual” screening mammography time frame, begin with the month after the month in which a screening mammography was performed and count until 11 full months have elapsed. (For example, if Mrs. Smith received a screening mammography examination at any time in March 2005, start counting in April 2005 and continue until 11 full months have elapsed, i.e.,

February, 2006. The next annual mammography screening test may be done as early as March 1, 2006.) (CMS Reference: IOM Pub 100-04 Section 20)

NOTE: Physicians treating women between the ages 35-39 should make every effort to determine if a baseline mammogram has already been submitted and approved by Medicare prior to recommending a second mammogram.

Procedure Codes and Descriptors

For dates of service January 1, 2007 and after, use the following list of procedure codes when billing mammography services:

- 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 codes 77055, 77056, G0204 and G0206 separately in addition to the primary procedure performed)
- 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 codes 77057 and G0202 separately in addition to the primary procedure performed)
- 77055*** Mammography; unilateral (Diagnostic)
- 77056 *** Mammography; bilateral (Diagnostic)
- 77057 *** Screening mammography, bilateral (two view film study of each breast)
- G0202** Screening mammography, producing direct digital image, bilateral, all views.
- G0204** Diagnostic mammography, producing direct digital image, bilateral, all views.
- G0206** Diagnostic mammography, producing direct digital image, unilateral, all views.

** For claims with dates of service prior to January 1, 2007, providers report CPT codes 76082, 76083, 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.*

GG Modifier

When a screening mammography turns to a diagnostic mammography on the same day for the same beneficiary, add the “-GG” modifier to the diagnostic code and bill both codes on the same claim. Both services are reimbursable by Medicare.

NOTE: Modifier GG is used to show that the diagnostic test performed on the same date as the screening test is appropriate, and is used for tracking purposes only.

Diagnosis Criteria

Report ICD-9-CM code V76.11 or V76.12 as the primary or principal diagnosis code on claims that contain ONLY SCREENING mammography services.

Report ICD-9-CM code V76.11 or V76.12 as the secondary or other diagnosis on claims that contain OTHER services in addition to a screening mammography.

Coverage and Billing Tips

Patients with breast implants do not automatically qualify for diagnostic mammograms. It is quite possible for a patient who has a breast implant to receive a screening mammogram. **CMS Reference: IOM Pub 100-04 Chapter 18 Section 20** of Medicare regulations defines diagnostic mammogram as a radiological procedure furnished to men or women with signs or symptoms of breast disease. This definition does not allow for diagnostic coverage of the breast implant patient unless the patient meets the specific terms of the diagnostic mammogram description. This reference also indicates that a screening mammogram service “must be at a minimum, a two view exposure of each breast”. This definition makes it clear that certain screening mammograms may require more than two view exposures of each breast. ICD-9-CM diagnosis code 996.54 (mechanical complications due to breast prosthesis) may be used to identify patients with breast implants.

Billing Instructions for Computer-Aided Detection Devices (CAD)

- Diagnostic Mammography - HCPCS code **77051** for CAD services is used for diagnostic mammography CAD services. List this code separately in addition to code for primary procedure (77055, 77056, G0204 and G0206).
- Screening Mammography - HCPCS code **77052** for CAD services is used for screening mammography CAD services. List this code separately in addition to code for primary screening mammography procedure (76092 and G0202).
- There is no Part B deductible. However, coinsurance is applicable.

NOTE: You cannot bill an add-on code without also billing for the appropriate mammography code. If just the add-on code is billed, the service will be denied.

Diagnostic and Screening Mammograms Performed With New Technologies (§4601.6), Mammography utilizes a direct x-ray of the breast. By contrast, the CAD process uses a laser beam to scan the mammography film from a film (analog) mammography, converts it into digital data for the computer, and analyzes the video display for areas suspicious for cancer. The CAD process used with digital mammography analyzes the data from the mammography on a video display for suspicious areas. The patient is not required to be present for the CAD process. Screening and diagnostic mammography’s (film and digital) are subject to the FDA certification. However, CAD equipment does not require FDA certification.

Reimbursement Policy

Medicare pays 80% of the allowed amount of the physician fee schedule. These services are not subject to deductible.

For more information visit the IOM on the CMS website at: www.cms.gov/manuals

(CMS Reference: Pub 100-04 Chapter 18 Section 20)

MEDICAL NUTRITION THERAPY

Medicare covers Medical Nutrition Therapy (MNT) services when furnished by a registered dietitian or nutrition professional. Registered dietitian or nutrition professionals are defined by CMS as a dietitian or nutritionist who holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or equivalent foreign degree). The professional must have completed at least 900 hours of supervised dietetics practice and is licensed or certified as a dietitian or nutrition professional by the state as a registered dietitian. Other types of providers do not qualify for reimbursement of this service.

Coverage for MNT is only available for those beneficiaries with diabetes or renal disease, and a physician's referral is required. Registered dietitians and nutrition professionals can receive direct Medicare reimbursement.

General Conditions of Coverage

The following are the general conditions of coverage:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease;
- The number of hours covered in an episode of care may not be exceeded (3 hours);
- Services may be provided either on an individual or group basis without restrictions;
- For a beneficiary with a diagnosis of diabetes, Diabetes Self Management Training (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. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full 3 hours of MNT.

Instructions for Using the Medical Nutrition Therapy Codes

Only registered dietitians or nutrition professionals who meet the specified requirements will be reimbursed for MNT services. These services cannot be paid "incident to" physician services. Registered dietitians and nutrition professionals must accept assignment. As with the diabetes self-management training benefit, payment is only made for MNT services actually attended by the beneficiary and documented by the provider and for beneficiaries that are not inpatients of a hospital or skilled nursing facility.

The treating physician must make a referral for MNT services 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 any

reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis.

The name of the referring physician must be in Item 17. The NPI of the referring physician must be reported in item 17a on the Form CMS-1500 (or electronic equivalent) submitted by a registered dietitian or nutrition professional. Claims submitted for MNT services without physician referrals will be subject to return without processing.

Procedure Codes and Descriptors

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

NOTE: This CPT code is to be used for the initial visit. This code should be used only once a year, for the 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 Reassessment and intervention, individual, face-to-face with patient, each 15 minutes.

NOTE: This code should be billed for all individual reassessments and all interventions after the initial patient's medical condition that affects the nutritional status of the patient.

97804 Group (2 or more individual(s)), each 30 minutes.

NOTE: Use this code for all group visits, initial and subsequent. This code can also be used when there is a change in the patient's condition that affects the nutritional status of the patient and the patient is attending in a group.

When there is a change in the condition of the beneficiary, these codes are billable:

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

NOTE: These G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered, (3 hours in the initial calendar year, and 2 follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary.

Reimbursement Policy

The allowed amount for MNT services is 85% of the physician fee schedule amount. Medicare reimburses 80% of the allowed amount. Medicare deductible and coinsurance apply to these services.

For more information visit the IOM on the CMS website at <http://www.cms.gov/manuals>
(CMS Reference: Pub 100-04 Chapter 4 Section 300)

PNEUMOCOCCAL PNEUMONIA VACCINATION (PPV)

Initial Medicare coverage for PPV is provided for:

- Individuals age 65 and older;
- Immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and
- Individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation).

Revaccination may be administered only to individuals at the highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years have passed since receipt of a previous dose of pneumococcal vaccine. Providers should inquire if the patient has had a prior vaccination.

Procedure Codes and Descriptors

- 90732 Pneumococcal Polysaccharide Vaccine, 23 Valent, Adult dosage for subcutaneous or intramuscular use
- G0009 Administration of Pneumococcal vaccine when no physician fee schedule service is performed on the same day

Diagnosis Criteria

Use ICD-9-CM V03.82 (vaccine for Streptococcus Pneumonia) for pneumococcal vaccination.

As of October 2, 2006, providers may report diagnosis code V06.6 on claims for PPV and/or Influenza Virus vaccines when the purpose of the visit was to receive both vaccines.

V06.6 PPV and Influenza

Reimbursement Policy

Assignment must be taken on all drugs and biologicals covered under Medicare Part B. The vaccine is paid at 100% of the Medicare allowed amount and will not be applied to the deductible. The 5% differential between participating and nonparticipating providers does not apply.

For administration code G0009, mandatory assignment does not apply. Nonparticipating physicians may bill the administration at their customary fee. Medicare pays 100% of the allowed amount. The deductible and coinsurance do not apply to this service.

For more information visit the IOM on the CMS website at: www.cms.gov/manuals
(CMS Reference: Pub 100-04 Chapter 18 Section 10)

PROSTATE CANCER SCREENING

Medicare covers prostate cancer screening tests and procedures for the early detection of prostate cancer under Sections 1861(s) (2) (P) and 1861(oo) of the Social Security Act (as added by §4103 of the Balanced Budget Act of 1997). Coverage currently includes screening digital rectal examinations and Prostate Specific Antigen blood tests.

Screening Digital Rectal Examination

This test is a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate. Medicare pays for this examination when it is performed on a male Medicare beneficiary age 50 or older at a frequency of once every 12 months when performed by one of the following:

- Physician (Doctor of medicine or osteopathy)
- Qualified physician assistant
- Qualified nurse practitioner
- Qualified nurse specialist
- Qualified certified nurse midwife

Procedure Codes and Descriptors

The appropriate screening (V) code must be chosen when billing Medicare.

To report this service use: **G0102** Prostate cancer screening; digital rectal examination.

Reimbursement Policy

Medicare pays 80% of the approved amount of the physician fee schedule, or the submitted charge, whichever is lower. Deductible and coinsurance do apply.

Screening Prostate Specific Antigen (PSA) Blood Test

This test detects the marker for adenocarcinoma of the prostate. This tumor marker can predict residual tumors in the postoperative phase of prostate cancer. PSA is not in itself a diagnostic test, however once a diagnosis has been established this is used as a marker to follow the progress of most prostate tumors. PSA also aids in managing cancer patients and in detecting metastatic or persistent disease.

Medicare pays for this examination when it is performed on a male Medicare beneficiary age 50 or older at a frequency of once every 12 months when performed by one of the following:

- Physician (Doctor of medicine or osteopathy)
- Qualified physician assistant
- Qualified nurse practitioner
- Qualified nurse specialist
- Qualified certified nurse midwife

Procedure Codes and Descriptors

G0103 Prostate cancer screening: prostate specific antigen test (PSA).

Diagnosis Criteria

Prostate cancer screening digital rectal examinations and screening Prostate Specific Antigen (PSA) blood tests must be billed using screening (“V”) code V76.44 (Special Screening for Malignant Neoplasms, Prostate).

Reimbursement Policy

Because this is a laboratory test Medicare pays at 100% of the allowed amount and the Medicare deductible does not apply.

For more information visit the IOM on the CMS website at: www.cms.gov/manuals
(CMS Reference: Pub 100-04 Chapter 18 Section 50)

SCREENING PAP SMEARS

Medicare covers a screening pap smear once every two years (at least 23 months must have passed following the month during which the beneficiary received her last covered pap smear). Reimbursement can be made more frequently when:

- There is evidence on the basis of medical history or other findings that the patient is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 2 years; and at least 11 months have passed following the month that the last covered pap smear was performed, or
- The patient is at high risk of developing cervical or vaginal cancer and at least 11 months have passed following the month that the last covered screening pap smear was performed. The high risk factors for cervical and vaginal cancer are:
 - 1) Early onset of sexual activity (under 16 years of age)
 - 2) Multiple sexual partners (5 or more in a lifetime)
 - 3) History of a sexually transmitted disease (including HIV infection)
 - 4) Fewer than three negative or any Pap smears within the previous 7 years
 - 5) DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

Diagnosis Coding

For asymptomatic low-risk patients use ICD-9-CM code **V76.2** (special screening for malignant neoplasm, cervix), **V76.49** (for a patient who does not have a uterus or cervix), or code **V76.47** (special screening for malignant neoplasm, vagina) or **V72.31** (routine gynecological examination).

Use **V15.89** (other specified personal history presenting hazards to health) for high-risk beneficiaries.

Reference MLN Matters MM3659

Procedure Codes and Descriptors

Paid Under the Physician Fee Schedule

- Q0091** Screening Pap smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory;
- P3001** Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by a physician.
- G0124** Screening cytopathology, cervical or vaginal, collected in preservation fluid, automated thin layer preparation, requiring interpretation by physician.

Preventive Services Billing Guide

G0141 Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual re-screening, requiring interpretation by physician.

Paid Under the Clinical Lab Fee Schedule

P3000 Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision, and

G0123 Screening cytopathology, cervical or vaginal collected in preservation fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision.

G0143 Screening cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, with manual evaluation and reevaluation by cytotechnologist under physician supervision.

G0144 Screening cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer-assisted reevaluation by cytotechnologist under physician supervision.

G0145 Screening cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer-assisted reevaluation using cell selection and review under physician supervision.

G0147 Screening cytopathology smears, cervical or vaginal performed by automated system under physician supervision.

G0148 Screening cytopathology smears, cervical or vaginal, performed by automated system with manual reevaluation.

Reimbursement Policy

Medicare reimburses 100% for Pap smears paid under the clinical lab fee schedule. The deductible and coinsurance do not apply. Medicare pays 80% of the approved amount for the collection (services paid under the physician fee schedule) based on the physician fee schedule amount for the service, or the submitted charge, whichever is lower. The deductible is waived but the coinsurance does apply.

For more information visit the IOM on the CMS website at: www.cms.gov/manuals
(CMS Reference: Pub 100-04 Chapter 18 Section 30)

SCREENING PELVIC EXAMINATIONS

Section 1861(nn) of the Social Security Act (42 USC 1395x (nn)) provides coverage of a screening pelvic examination for all female beneficiaries once every 24 months or once every 12 months if the patient is at high risk for cervical or vaginal cancer, or she is of childbearing age and have had an abnormal Pap smear in the past 24 months. A screening pelvic examination should include at least seven of the following eleven elements:

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

- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses.

Pelvic examination (with or without specimen collection for smears and cultures):

- 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); and
- Anus and perineum.

The factors for women who are considered **high-risk** and are of childbearing age, who have had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding two years are:

- **Cervical Cancer High Risk Factors**
 - Early onset of sexual activity (under 16 years of age)
 - Multiple sexual partners (five or more in a lifetime)
 - History of a sexually transmitted disease (including HIV infection)
 - Fewer than three negative or any Pap smears within the previous 7 years
- **Vaginal Cancer High Risk Factors**
 - DES (diethylstilbestrol) exposed daughters of women who took DES during pregnancy.

Procedure Codes and Descriptors

Use code G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination) to report a pelvic and clinical breast examination.

Diagnosis Criteria

For asymptomatic low-risk patients use ICD-9-CM codes:

- V76.2** Special screening for malignant neoplasm, cervix
- V76.47** Special screening for malignant neoplasm, vagina
- V76.49** Special screening for malignant neoplasm, other site (use for a patient who does not have a uterus or cervix)
- V72.31** Routine gynecological examination (Note: V72.31 was effective July 1, 2005.)

For high-risk patients use ICD-9-CM code **V15.89**, other specified personal history presenting hazards to health to indicate that one or more of these factors are present.

Reimbursement Policy

Medicare pays 80% of the approved amount based on the physician's fee schedule amount for the service, or the submitted charge whichever is lower. Deductible is waived for this service but the co-insurance does apply. The 5% differential between participating and non-participating providers applies.

For more information visit the IOM on the CMS website at: www.cms.gov/manuals
(CMS Reference: Pub 100-04 Chapter 18 Section 40)

SMOKING AND TOBACCO-USE CESSATION SERVICES

Effective March 22, 2005, Medicare Part B covers two new levels of counseling, intermediate (G0375) and intensive (G0376), for smoking and tobacco use cessation. The coverage is limited to beneficiaries who use tobacco and have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use based on Food and Drug Administration (FDA) approved information. Patients must be competent and alert at the time that services are provided. To be eligible:

- Beneficiary must have a condition that is adversely affected by smoking or tobacco use
- Metabolism or dosing of a medication used to treat a condition has adversely been affected by smoking or tobacco use.

Medicare will cover 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions in a 12-month period.

Coverage

Medicare covers 2 types of counseling:

- Intermediate cessation counseling is 3 to 10 minutes per session; and
- Intensive cessation counseling is greater than 10 minutes per session.

Procedure Codes and Descriptors

For dates of service on or after January 1, 2008, smoking and tobacco cessation counseling services must be reported with two new procedure codes.

99406 Greater than 3 to 10 minutes per session

99407 Greater than 10 minutes per session

Please note, for dates of service prior to January 1, 2008, use the following procedure codes to report smoking and tobacco cessation counseling services.

G0375 Greater than 3 to 10 minutes per session

G0376 Greater than 10 minutes per session

Diagnosis Criteria

- Services must be reasonable and necessary and must be documented in the patient's medical record to adequately demonstrate that Medicare coverage conditions were met for any services provided and billed to Medicare for smoking and tobacco use cessation counseling.

Advanced Beneficiary Notice

Providers should have the patient sign an Advance Beneficiary Notice if all the specified conditions for coverage are not met.

Reimbursement Policy

Medicare pays 80% of the approved amount based on the physician's fee schedule amount for the service, or the submitted charge whichever is lower. The deductible and coinsurance do apply. The 5% differential between participating and non-participating providers applies.

For more information visit the IOM on the CMS website at: www.cms.gov/manuals
(CMS Reference: IOM Pub 100-3 Chapter 1, Part 4, Section 210.4)

ULTRASOUND SCREENING FOR ABDOMINAL AORTIC ANEURYSM (AAA)

Effective January 1, 2007, Medicare will provide coverage of an Ultrasound screening for Abdominal Aortic Aneurysm for Medicare beneficiaries.

Patient Eligibility

Medicare patients are eligible to receive the screening AAA once per life time. Medicare beneficiaries must also meet the following risk categories:

- Has a family history of abdominal aortic aneurysm
- Is a man age 65-75 who has smoked at least 100 cigarettes in his lifetime

Preventive Services Billing Guide

- Is a Medicare beneficiary who manifests other risk factors in a beneficiary category recommended by the United States Preventive Services Task Force regarding AAA as specified by the Secretary of Health and Human Services through the national coverage determination process

Medicare coverage criteria is required to be met for coverage, the Medicare coverage criteria is as follows:

- The patient receives a referral for the Ultrasound as a result of an Initial Preventive Physical examination
- The test is performed by a provider or supplier who is authorized to provide covered diagnostic services
- The patient has not received a preventive ultrasound screening under the Medicare program

Deductible and Coinsurance

The Medicare Part B deductible is waived for this service effective January 1, 2007. The co-insurance is applicable to this procedure.

Billing Information

If the screening is provided in a physician's office, the service is billed to the carrier:

G0389 (Ultrasound, B-scan and or real time with image documentation; for abdominal aortic aneurysm (AAA)).

Modifiers TC and 26 may apply. Payment is made under the Medicare physician fee schedule.

For more information visit the IOM on the CMS website at: www.cms.gov/manuals
(CMS Reference: Pub 100-04 Chapter 18 Section 110)

EDUCATIONAL PRODUCTS AND INFORMATIONAL RESOURCES FOR HEALTH CARE PROFESSIONALS

CMS has developed a variety of educational products to increase the awareness of Medicare's Preventive Care Coverage of disease prevention and early detection. Information, educational tools and resources can be found at the following link.

<http://www.cms.gov/MLN MattersArticles/downloads/SE0630.pdf>

BILLING FOR COVERED, PREVENTIVE, AND NON-COVERED SERVICES ON THE SAME DAY

NHIC often receives inquiries regarding how to bill for covered, non-covered, and preventive services on the same day. This question arises when physicians perform annual physical examinations on their patients the same time they perform follow-up evaluation of existing medical conditions.

The following examples describe typical situations, and the appropriate billing process:

- A physician furnishes a Medicare beneficiary a covered examination for evaluation of a medical condition at the same place and on the same occasion as a preventive medicine visit (CPT codes 99381-99397). Medicare would normally pay for the covered visit at the level that meets the criteria for coverage as reasonable and necessary if it were billed on a different day (for this example, let's use 99213). The preventive service would be denied as non-covered screening, and the payment is the responsibility of the patient.
- The physician may charge the beneficiary, as a charge for the non-covered portion of the service, the amount he/she has established as the charge for the preventive medicine service, less the amount that would be owed by Medicare and the patient for the covered visit. In this example, the physician normally bills \$200 for a full preventive service. His/her charge for the 99213 is \$53.29, the Medicare fee schedule amount.

Service	Procedure	DX Code	Fee
Preventive Exam	99397	V70.0	\$146.71
Medically Necessary Exam	99213	250.00	\$ 53.29

The physician may collect \$146.71 from the beneficiary for the preventive service (\$200 less \$53.29) plus the 20% coinsurance of \$10.66 for the covered visit. The patient is responsible for \$157.37, and Medicare would pay \$42.63.

The physician is not required to give the beneficiary written advance notice of non-coverage of the part of the visit that constitutes a routine preventive visit. However, it is good business practice to provide this information to the beneficiary.

We have received requests for information on how to bill for multiple services, such as routine physical examinations, covered screening mammography's, covered screening pelvic examinations, and medically necessary services when performed on the same day. Careful billing of these services is essential for proper adjudication by Medicare. The following reflects how to identify what portions of your fees should be apportioned to covered services, and how these services may be billed.

Preventive Services Billing Guide

- As in the above example, a physician charges \$200 for a routine preventive examination. This examination normally includes those items which are covered under a screening pelvic examination (examination of the breast, digital rectal examination, and pelvic examination). Medicare allows for these services under procedure code G0101. The physicians charge for this service alone is \$36.86, the Medicare fee schedule amount.
- The physician should deduct the charge for the covered screening service from the charge for the non-covered preventive service.

The charges then become:

Preventive Examination = \$163.14

Screening Pelvic Examination = \$36.86

- In addition to the examinations, the physician performs a screening mammography and orders various blood work. The patient is on cholesterol medication and is due for a check of the effects of the medication on the liver, so the physician orders a hepatic panel. The screening mammography is within the time limit for coverage, so the physician performs and bills 76092, Screening Mammography.

The coding might look something like:

Service	Procedure	DX Code	Fee
Preventive Exam	99397	V70.0	\$163.14
Pelvic Exam	G0101	V76.2	\$ 36.86
Screening Mammography	76092	V76.12	\$ 90.00

The patient would be responsible for the full cost of the preventive exam, plus 20% of the Medicare allowance for the pelvic exam and screening mammography.

On the orders he/she submits to the laboratory, the physician indicates the reason for the tests as screening for all the blood work, with the exception of the hepatic panel. For that the physician indicates hypercholesterolemia (272.0).

Coverage and Billing Tips

- Explain to your patient what you are doing and what their financial responsibility will be **before** services are rendered.
- Clearly document the medical record to support the services rendered.
- When ordering services to be performed by an outside laboratory, specify the condition for which you are ordering the tests. State clearly the screening conditions and tests and separate them from services that are reasonable and necessary for the patient's condition. Provide the appropriate diagnosis to support the necessity for the non-screening tests.

NATIONAL CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: <http://www.cms.gov/NationalCorrectCodInitEd/>

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address: <http://www.cms.gov/BNI/>

ABN Modifiers

- GA Waiver of liability statement issued, as required by payer policy
- GX Notice of liability issued, voluntary under payer policy
- GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit
- GZ Item or service expected to be denied as not reasonable and necessary (forgot to issue ABN to patient)

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

http://www.medicarenhic.com/ne_prov/policies.shtml

NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: <http://www.cms.gov/mcd/search.asp>

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

Preventive Services Billing Guide

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

Maureen Akhouzine, Manager
Safeguard Services (SSG)
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@hp.com

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

RECOVERY AUDIT CONTRACTOR

The Centers for Medicare & Medicaid Services (CMS) has retained Diversified Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on <http://www.dcsrac.com/>

COMPREHENSIVE ERROR RATE TESTING

In an effort to determine the rate of Medicare claims that are paid in error, CMS developed the Comprehensive Error Rate Testing (CERT) program. This program will determine the paid claim error rates for individual Medicare contractors, specific benefit categories, and the overall national error rate. This is accomplished by sampling random claims on a nationwide basis, while insuring that enough claims are sampled to evaluate the performance of each Medicare contractor. The CERT program is administered by two contractors:

CERT DOCUMENTATION CONTRACTOR (CDC) - The CDC requests and receives medical records from providers.

CERT REVIEW CONTRACTOR (CRC)-The CRC's medical review staff reviews claims that are paid and validate the original payment decision to ensure that the decision was appropriate. The sampled claim data and decisions of the independent medical reviewers will be entered into a tracking and reporting database.

The outcomes from this project are a national paid claims error rate, a claim processing error rate, and a provider compliance rate. The tracking database allows us to quickly identify emerging trends.

Preventive Services Billing Guide

For more information please click on <http://www.cms.gov/CERT/>

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date**. The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or SSN of the provider to utilize the IVR system.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 4:00 p.m. - Friday

866-801-5304

Dedicated Reopening Requests Only

Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. - Friday

877-757-7781

MAILING ADDRESS DIRECTORY

Initial Claim Submission	
Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 5912 New York, NY 10087-5912
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

** Reopening requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:

www.medicarenhic.com

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

Reconsideration (Second Level of Appeal)

First Coast Service Options Inc.

QIC Part B North Reconsiderations

P.O. Box 45208

Jacksonville, FL 32232-5208

INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

<http://www.cms.gov/center/coverage.asp>

<http://www.cms.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

<http://www.cms.gov/MLNGenInfo/>

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

<http://www.cms.gov/OpenDoorForums/>

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

<http://www.cms.gov/CMSForms/>

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)

<http://cms.gov/BNI/>

American Medical Association

<http://www.ama-assn.org/>

CMS

<http://www.cms.gov>
<http://www.medicare.gov>

CMS Correct Coding Initiative

<http://www.cms.gov/NationalCorrectCodInitEd/>

CMS Physician's Information
Resource for Medicare

<http://www.cms.gov/center/physician.asp?>

Electronic Prescribing

<http://www.cms.gov/erx incentive/>

Preventive Services Billing Guide

Evaluation and Management Documentation Guidelines

http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Federal Register

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

HIPAA

<http://www.cms.gov/HIPAAGenInfo/>

National Provider Identifier (NPI)

<http://www.cms.gov/NationalProvIdentStand/>

NPI Registry

<https://nppes.cms.gov/NPPES/NPIRegistryHome.do>

Physicians Quality Reporting

<http://www.cms.gov/pqri/>

Provider Enrollment, Chain, and Ownership System (PECOS)

http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment

<http://www.cms.gov/MedicareProviderSupEnroll/>

U.S. Government Printing Office

<http://www.gpoaccess.gov/index.html>

Revision History:

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	7/06/2010	Susan Kimball	Ayanna YanceyCato	Release of document on the new NHIC Quality Portal

NHIC, Corp.

**75 Sgt. William Terry Drive
Hingham, MA 02044**

Website:

<http://www.medicarenhic.com>

CMS Websites

<http://www.cms.gov>

<http://www.medicare.gov>