Medicare Intermediary Manual Part 3 - Claims Process

Department of Health and Human Services

Health Care Financing Administration

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CHANGE REQUEST 1087

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Sec. 3631 (Cont.)	6-178.3F - 6-178.3G (2 pp.)	6 - 178.3F (l p.)

MANUALIZATION--EFFECTIVE DATE: Not Applicable

Section 3631, HCPCS for Hospital Outpatient Radiology Services and Other Diagnostic Procedures, incorporates instructions previously released in Program Memoranda (PM) AB-99-20, Change Request #856 dated April 1999 and AB-99-51, Change Request #919 dated July 1999. It provides billing and payment instructions when billing for External Counterpulsation (ECP) with dates of service on or after July 1, 1999. Instruct hospitals to report HCPCS code G0166 (External counterpulsation, per treatment session) for claims with dates of service on or after January 1, 2000 when billing for ECP. This HCPCS code is included in the 2000 HCFA Common Procedure Coding System (HCPCS) Update that was released in October 1999. For claims with dates of service prior to January 1, 2000, ECP services are reported using 93799 as previously instructed.

CLARIFICATION--EFFECTIVE DATE: April 1, 2000
IMPLEMENTATION DATE: April 1, 2000

Section 3631, HCPCS for Hospital Outpatient Radiology Services and Other Diagnostic Procedures, clarifies information not originally in the program memoranda and deletes all references to Enhanced External Counterpulsation (EECP) and is replaced by ECP. Refer to CIM §35-74 for coverage criteria.

NOTE: Review any ECP local medical review policy that may be in place and perform provider education.

These instructions should be implemented within your current operating budget.

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

Coding Requirements.--Providers must report HCPCS codes for bone mass measurements under revenue code 320. They are required to report the number of units, and line item dates of service per revenue code line for each bone mass measurement reported. Line item date of service reporting is effective for claims with dates of service on or after October 1, 1998. You must return bills that span two or more dates if a line item date of service is not entered for each code reported. Providers utilizing the UB-92 flat file use record type 61 to report the bone mass procedure. Record type (Field No. 1), sequence number (Field No.2), patient control number (Field No. 3), revenue code 320 (Field No. 4), HCPCS code, as appropriate (Field No. 5), units of service (Field No. 8), date of service (Field No. 12, Field No. 9 may be utilized in version 4.1 until September 30, 1998) and outpatient total charges (Field No. 10) are required.

Providers utilizing the hard copy UB-92 (HCFA Form 1450) report the appropriate HCPCS code in FL 44 "HCPCS/Rates," and revenue code 320 in FL 42 "Revenue Code." The date of service is reported in FL 45 "Service Date" (MMDDYYYY) and the number of service units in FL 46 "Service Units."

HCPCS codes G0130, G0131, G0132, and G0133 will not be recognized as valid HCPCS codes in the outpatient code editor (OCE) 13.1R1. In order to process claims containing these codes, you must add these codes to the tables you use to accept local codes. These HCPCS codes will be added to the OCE, which will be effective October 1, 1998.

Payment Methodology.--Part B deductible and coinsurance apply. Pay for bone mass measurements under current payment methodologies for radiology services.

o. External Counterpulsation (ECP).--External Counterpulsation (ECP), commonly referred to as enhanced external counterpulsation, is a non-invasive outpatient treatment for coronary artery disease refractory to medical and/or surgical therapy. Although these and similar devices are cleared by the Food and Drug Administration (FDA) for use in treating a variety of conditions, including stable angina pectoris, acute myocardial infarction, and cardiogenic shock, Medicare coverage is limited to its use in patients with stable anginal pectoris, since only that use has developed sufficient evidence to demonstrate its medical effectiveness. Pay for claims with dates of service on or after July 1,1999 when this limited coverage is met. Payment is made to hospitals for the facility costs it incurs under Part B on a reasonable cost basis. Payment is also made to PPS-exempt hospitals for the facility costs it incurs on a reasonable cost basis. Deductible and coinsurance apply. Other uses of this device and similar devices remain non-covered. The non-coverage of hydraulic versions of these types of devices remains in force. (See the Coverage Issues Manual §35-74 for more information on the coverage criteria.)

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

Applicable Bill Types.--The appropriate bill types are 12X, 13X, 83X, and 85X.

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

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

HCPCS Reporting.--For claims with dates of service on or after July 1, 1999 hospitals report CPT code 93799 (Unlisted cardiovascular service or procedure). For dates of service on or after January 1, 2000 hospitals report HCPCS code G0166, (External counterpulsation, per treatment session). Hospitals utilizing the UB-92 flat file use record type 61, HCPCS code (Field No. 5) to report the CPT/HCPCS code. Hospitals utilizing the hard copy UB-92 (Form HCFA-1450) report the CPT/HCPCS code in FL 44 "HCPCS/Rates."

Codes for external cardiac assist (92971), ECG rhythm strip and report (93040 or 93041), pulse oximetry (94760 or 94761) and plethysmography (93922 or 93923) or other monitoring tests for examining the effects of this treatment are not medically necessary with this service and should not be paid on the same day, unless they occur in a clinical setting not connected with the delivery of the ECP.

Post Pay Review.--As with any claim, but particularly in view of the limitations on this coverage, you may decide to conduct post-payment reviews to determine that use of ECP is consistent with this instruction.