Medicare Claims Processing Manual

Chapter 13 - Radiology Services and Other Diagnostic Procedures

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10 - ICD -9-CM Coding for Diagnostic Tests

(Rev. 1, 10-01-03)

B3-15021.1

The ICD-9-CM Coding Guidelines for Outpatient Services (hospital-based and physician office) have instructed physicians to report diagnoses based on test results. Instructions and examples for coding specialists, contractors, physicians, hospitals, and other health care providers to use in determining the use of ICD-9-CM codes for coding diagnostic test results is found in Chapter 23.

10.1 - Billing Part B Radiology Services and Other Diagnostic Procedures

(Rev. 1, 10-01-03)

SNF-533

Acceptable HCPCS codes for radiology and other diagnostic services are taken primarily from the CPT-4 portion of HCPCS. Payment is the lower of the charge or the Medicare physician fee schedule amount. Deductible and coinsurance apply, and coinsurance is based on the allowed amount.

For claims to intermediaries (FIs), revenue codes, HCPCS code, line item dates of service, units, and applicable HCPCS modifiers are required. Charges must be reported by HCPCS code. If the same revenue code applies to two or more HCPCS codes, providers should repeat the revenue code and show the line item date of service, units, and charge for each HCPCS code on a separate line.

20 - Payment Conditions for Radiology Services

(Rev. 1, 10-01-03)

B3-15022

20.1 - Professional Component (PC)

(Rev. 1, 10-01-03)

Carriers must pay for the PC of radiology services furnished by a physician to an individual patient in all settings under the fee schedule for physician services regardless of the specialty of the physician who performs the service. For services furnished to hospital patients, carriers pay only if the services meet the conditions for fee schedule payment and are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as an interpretation of diagnostic procedures and the PC of

therapeutic procedures. The interpretation of a diagnostic procedure includes a written report.

20.2 - Technical Component (TC)

(Rev. 1, 10-01-03)

20.2.1 - Hospital and Skilled Nursing Facility (SNF) Patients

(Rev. 1, 10-01-03)

Carriers may not pay for the technical component (TC) of radiology services furnished to hospital patients. Payment for physicians' radiological services to the hospital, e.g., administrative or supervisory services, and for provider services needed to produce the radiology service, is made by the fiscal intermediary (FI) as a provider service.

FIs include the TC of radiology services for hospital inpatients except Critical Access Hospitals (CAH) in the prospective payment system (PPS) payment to hospitals.

For CAHs, payment is made by the FI based on reasonable cost.

Radiology and other diagnostic services furnished to hospital outpatients are paid under the Outpatient Prospective Payment System (OPPS) to the hospital. This applies to bill types 12X, 13X, and 14X that are submitted to the FI.

As a result of SNF Consolidated Billing (Section 4432(b) of the Balanced Budget Act (BBA) of 1997), carriers may not pay for the TC of radiology services furnished to Skilled Nursing Facility (SNF) inpatients during a Part A covered stay. The SNF must bill radiology services furnished its inpatients in a Part A covered stay and payment is included in the SNF Prospective Payment System (PPS).

Radiology services furnished to outpatients of SNFs may be billed by the supplier performing the service or by the SNF under arrangements with the supplier. If billed by the SNF, FIs pay according to the Medicare Physician Fee Schedule. SNFs submit claims to the FI with type of bill 22X or 23X.

20.2.2 - Services Not Furnished in Hospitals

(Rev. 1, 10-01-03)

Carriers must pay under the fee schedule for the TC of radiology services furnished to beneficiaries who are not patients of any hospital, and who receive services in a physician's office, a freestanding imaging or radiation oncology center, or other setting that is not part of a hospital.

20.2.3 - Services Furnished in Leased Departments

(Rev. 1, 10-01-03)

In the case of procedures furnished in a leased hospital radiology department to a beneficiary who is neither an inpatient nor an outpatient of any hospital, e.g., the patient is referred by an outside physician and is not registered as a hospital outpatient, both the PC and the TC of the services are payable under the fee schedule by the carrier.

20.2.4 - Purchased Diagnostic Tests - Carriers

(Rev. 1, 10-01-03)

B3-15048

Section 1842(n) of the Social Security Act (the Act) establishes payment rules for diagnostic tests billed by a physician but performed by an outside supplier. For this purpose, diagnostic tests are tests covered under §1861(s)(3) of the Act other than clinical diagnostic laboratory tests. These include, but are not limited to, such tests as x-rays, EKGs, EEGs, cardiac monitoring, ultrasound, and the technical component of physician pathology services furnished on or after January 1, 1994. (Note that screening mammography services are covered under another provision of the Act and are not subject to the purchased services limitation.) These rules apply to the purchased test itself (the TC) and not to physicians' services associated with the test.

20.2.4.1 - Carrier Payment Rules

(Rev. 1, 10-01-03)

If a test is personally performed by a physician or is supervised by a physician, such physician may bill under the normal physician fee schedule rules. This includes situations in which the test is performed or supervised by another physician with whom the billing physician shares a practice. For this purpose, services under a physician's supervision has the same meaning as is required for services to be considered incident to a physician's service, i.e., direct supervision of the physician's own employees or of his or her medical group which constitutes a physician directed clinic. The supervision requirement is **not** met when the test is administered by supplier personnel regardless of whether the test is performed at the physician's office or at another location. In addition, for the physician supervision requirement to be met, the personnel must be employed by the physician or by his or her medical group in his, her, or its medical practice. The fact that a physician may have an ownership interest in the outside supplier is not material to this determination, and employees of such supplier are not considered the physician's employees for purposes of this provision.

If a physician bills for a diagnostic test performed by an outside supplier, the fee schedule amount for the purchased service equals the lower of the billing physician's fee schedule or the price he or she paid for the service. The lower figure is the fee schedule amount

for purposes of the limiting charge. The billing physician must identify the supplier (including the supplier's provider number) and the amount the supplier charged the billing physician (net of any discounts). The purchased amount and the fee are identified on the initial claim form. A physician who accepts assignment is permitted to bill and collect from the beneficiary only the applicable deductible and coinsurance for the purchased test. A physician who does not accept assignment is permitted to bill and collect from the beneficiary only the fee schedule amount (as defined above) for the purchased test. The limiting charge provision is not applicable.

If the physician does not identify the supplier and provide the other required information, no payment is allowed, and the physician may not bill the beneficiary any amount for the test.

20.2.4.2 - Payment to Physician for Purchased Diagnostic Tests

(Rev. 1, 10-01-03)

A physician or a medical group may submit the claim and (if assignment is accepted) receive the Part B payment, for the **technical component** of diagnostic tests which the physician or group purchases from an independent physician, medical group, or other supplier. (This claim and payment procedure does not extend to clinical diagnostic laboratory tests.) The purchasing physician or group may be the same physician or group as ordered the tests or may be a different physician or group. An example of the latter situation is when the attending physician orders radiology tests from a radiologist and the radiologist purchases the tests from an imaging center. The purchasing physician or group may not mark up the charge for a test from the purchase price and must accept the lowest of the fee schedule amount if the supplier had billed directly; the physician's actual charge; or the supplier's net charge to the purchasing physician or group, as full payment for the test even if assignment is not accepted.

In order to purchase a diagnostic test, the purchaser must perform the interpretation. The physician or other supplier that furnished the technical component must be enrolled in the Medicare program. No formal reassignment is necessary.

A - Purchased TC Services

Carriers must apply the purchased services limitation to the TC of radiologic services other than screening mammography procedures.

B - Payment to Supplier of Diagnostic Tests for Purchased Interpretations

A person or entity that provides diagnostic tests may submit the claim, and (if assignment is accepted) receive the Part B payment, for diagnostic test interpretations which that person or entity **purchases** from an independent physician or medical group if:

- The tests are initiated by a physician or medical group which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;

- The physician or medical group providing the interpretations does not see the patient; and

- The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary.

The purchaser must keep on file the name, the provider identification number and address of the interpreting physician. The rules permitting claims by a facility or clinic for services of an independent contractor physician on the physical premises of the facility or clinic are set forth in Chapter 1.

C - Sanctions

Physicians who knowingly and willfully, in repeated cases, bill Medicare beneficiaries amounts beyond those outlined in this chapter are subject to the penalties contained under §1842(j)(2) of the Act. Penalties are assigned after post-pay review depending on the severity.

D - Questionable Business Arrangements

No special charge or payment constraints are imposed on tests performed by a physician or a physician's employees under his or her supervision. However, attempts may be made by the medical diagnostic community to adjust or establish arrangements which continue to allow physicians to profit from other's work or by creating the appearance that the physician has performed or supervised his/her employees' performance of the service. Some of these arrangements may involve cardiac scanning services and mobile ultrasound companies leasing their equipment to physicians for the day the equipment is used and hiring out their staff to the physicians to meet the supervision requirement.

The bonafides of these arrangements are extremely suspect. The CMS views this arrangement as a transparent attempt to circumvent the prohibition against the markup on purchased diagnostic tests. The mere issuance of a W-2 from the physician does not automatically make the leasing company's technician the physician's employee for purposes of our employer-employee test. Rather, the determination as to a valid employer-employee relationship is dependent upon factors such as who has the right to hire and fire, who trains the employee, who is paying health and retirement benefits, who schedules work, who approves sick and vacation time, and so forth. If carriers have any doubt that a particular arrangement is a valid employer-employee relationship and/or believe that a physician is billing for a purchased diagnostic test in excess of the amount permitted, they refer the case to the Office of the Inspector General (OIG) for investigation as a potential violation of §1842(n) of the Act.

Another questionable arrangement to circumvent the purchased diagnostic service provision is for the ordering physician to reassign his/her payment for the interpretation of the test to the supplier. The supplier, in turn, bills for both the test and the interpretation and pays the ordering physician a fee for the interpretation. This

arrangement violates §1842(b)(6) of the Act, which prohibits Medicare from paying benefits due the person that furnished the service to any other person, subject to limited exceptions. In addition, this arrangement could constitute a violation of §1128B(b) of the Act, which prohibits remuneration for referrals (i.e., kickbacks).

Violations of §1128B(b) of the Act may subject the physician or supplier to criminal penalties or exclusion from the Medicare and Medicaid programs. Illegal remuneration for referrals can be found even when the ordering physician performs some service for the remuneration.

30 - Computerized Axial Tomography (CT) Procedures

(Rev. 1, 10-01-03)

Carriers do not reduce or deny payment for medically necessary multiple CT scans of different areas of the body that are performed on the same day.

The TC RVUs for CT procedures that specify "with contrast" include payment for high osmolar contrast media. When separate payment is made for low osmolar contrast media under the conditions set forth in §30.1.1, reduce payment for the contrast media as set forth in §30.1.2.

30.1 - Low Osmolar Contrast Media (LOCM) (HCPCS Codes A4644-A4646)

(Rev. 1, 10-01-03)

30.1.1 - Payment Criteria

(Rev. 1, 10-01-03)

Carriers make separate payments for LOCM (HCPCS codes A4644, A4645, and A4646) in the case of all medically necessary intrathecal radiologic procedures furnished to nonhospital patients. In the case of intraarterial and intravenous radiologic procedures, carriers pay separately for LOCM only when it is used for nonhospital patients with one or more of the following characteristics:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- A history of asthma or allergy;
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;
- Generalized severe debilitation; or

- Sickle cell disease.

If the beneficiary does not meet any of these criteria, the payment for contrast media is considered to be bundled into the TC of the procedure, and the beneficiary may not be billed for LOCM.

30.1.2 - Payment Level

(Rev. 1, 10-01-03)

LOCM pharmaceutical is considered to be a supply which is an integral part of the diagnostic test. However, determine payment in the same manner as for a drug furnished incident to a physician's service.

30.1.3 - SNF Billing and Intermediary (FI) Payment for Contrast Material Other Than Low Osmolar Contrast Material (LOCM) (Radiology)

(Rev. 1, 10-01-03)

SNF-533.1.F

When a radiology procedure is provided with contrast material, a SNF should bill using the CPT-4 code that indicates "with" contrast material. If the coding does not distinguish between "with" and "without" contrast material, the SNF should use the available code.

Contrast material other than LOCM may be billed separately in addition to the radiology procedure, or it may be billed as part of the amount for the radiology procedure. If the SNF bills separately for the contrast material and the charge for the procedure includes a charge for contrast material, the SNF must adjust the charge for the procedure to exclude any amount for the contrast material. Regardless of the billing method used, charges are subject to the fee schedule.

When billing separately for this contrast material, the SNF should use revenue code 0255 (drugs incident to radiology and subject to the payment limit) and report the charge on the same bill as the radiology procedure. The FI will not accept late charge bills for this service.

30.1.3.1 - FI Payment for Low Osmolar Contrast Material (LOCM) (Radiology)

(Rev. 1, 10-01-03)

SNF-533.1.G.

LOCM is paid on a reasonable cost basis when rendered by a SNF to its Part B patients (in addition to payment for the radiology procedure) when it is used in one of the situations listed below.

The following HCPCS are used when billing for LOCM.

HCPCS Code	Description (January 1. 1994, and later)
A4644	Supply of low osmolar contrast material (100-199 mgs of iodine);
A4645	Supply of low osmolar contrast material (200-299 mgs of iodine); *or*
A4646	Supply of low osmolar contrast material (300-399 mgs of iodine).

When billing for LOCM, SNFs use revenue code 0636. If the SNF charge for the radiology procedure includes a charge for contrast material, the SNF must adjust the charge for the radiology procedure to exclude any amount for the contrast material.

NOTE: LOCM is never billed with revenue code 0255 or as part of the radiology procedure.

The FI will edit for the intrathecal procedure codes and the following ICD-9-CM codes to determine if payment for LOCM is to be made. If an intrathecal procedure code is not present, or one of the ICD-9-CM codes is not present to indicate that a required medical condition is met, the FI will deny payment for LOCM. In these instances, LOCM is **not** covered and should not be billed to Medicare.

When LOCM Is Separately Billable and Related Coding Requirements

- In all intrathecal injections. HCPCS codes that indicate intrathecal injections are:

  70010 70015 72240 72255 72265 72270 72285 72295

One of these must be included on the claim; or

- In intravenous and intra-arterial injections only when certain medical conditions are present in an outpatient. The SNF must verify the existence of at least one of the following medical conditions, and report the applicable ICD-9-CM diagnosis code(s) either as a principal diagnosis code or other diagnosis codes on the claim:

- A history of previous adverse reaction to contrast material. The applicable ICD-9-CM codes are V14.8 and V14.9. The conditions which should not be considered adverse reactions are a sensation of heat, flushing, or a single episode of nausea or vomiting. If the adverse reaction occurs on that visit with the induction of contrast material, codes describing hives, urticaria, etc. should also be present, as well as a code describing the external cause of injury and poisoning, E947.8;

- A history or condition of asthma or allergy. The applicable ICD-9-CM codes are V07.1, V14.0 through V14.9, V15.0, 493.00, 493.01, 493.10, 493.11, 493.20, 493.21, 493.90, 493.91, 495.0, 495.1, 495.2, 495.3, 495.4, 495.5, 495.6, 495.7, 495.8 , 495.9, 995.0, 995.1, 995.2, and 995.3;

- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension. The applicable ICD-9-CM codes are:

  402.00 402.01 402.10 402.11 402.90 402.91

  404.00 404.01 404.02 404.03

  404.10 404.11 404.12 404.13

  404.90 404.91 404.92 404.93

  410.00 410.01 410.02 410.10 410.11 410.12

  410.20 410.21 410.22 410.30 410.31 410.32

  410.40 410.41 410.42 410.50 410.51 410.52

  410.60 410.61 410.62 410.70 410.71 410.72

  410.80 410.81 410.82 410.90 410.91 410.92

  411.1 415.0 416.0 416.1 416.8 416.9

  420.0 420.90 420.91 420.99 424.90 424.91

  424.99 427.0 427.1 427.2 427.31 427.32

  427.41 427.42 427.5 427.60 427.61 427.69

  427.81 427.89 427.9 428.0 428.1 428.9 429.0

  429.1 429.2 429.3 429.4 429.5 429.6 429.71

429.79 429.81 429.82 429.89 429.9 785.50 785.51 785.59

- Generalized severe debilitation. The applicable ICD-9-CM codes are 203.00, 203.01, all codes for diabetes mellitus, 518.81, 585, 586, 799.3, 799.4, and V46.1; or

- Sickle Cell disease. The applicable ICD-9-CM codes are 282.4, 282.60, 282.61, 282.62, 282.63, and 282.69.

40 - Magnetic Resonance Imaging (MRI) Procedures

(Rev. 1, 10-01-03)

Carriers do not make additional payments for three or more MRI sequences. The RVUs reflect payment levels for two sequences.

The TC RVUs for MRI procedures that specify "with contrast" include payment for paramagnetic contrast media. Carriers do not make separate payment under code A4647.

A diagnostic technique has been developed under which an MRI of the brain or spine is first performed without contrast material, then another MRI is performed with a standard (0.1mmol/kg) dose of contrast material and, based on the need to achieve a better image, a third MRI is performed with an additional double dosage (0.2mmol/kg) of contrast material. When the high-dose contrast technique is utilized, carriers:

- Do not pay separately for the contrast material used in the second MRI procedure;

- Pay for the contrast material given for the third MRI procedure through supply code A4643 when billed with CPT codes 70553, 72156, 72157, and 72158;

- Do not pay for the third MRI procedure. For example, in the case of an MRI of the brain, if CPT code 70553 (without contrast material, followed by with contrast material(s) and further sequences) is billed, make no payment for CPT code 70551 (without contrast material(s)), the additional procedure given for the purpose of administering the double dosage, furnished during the same session. Medicare does not pay for the third procedure (as distinguished from the contrast material) because the CPT definition of code 70553 includes all further sequences; and

- Do not apply the payment criteria for low osmolar contrast media in §30.1.2 to billings for code A4643.

40.1 – Magnetic Resonance Angiography

(Rev. 1, 10-01-03)

R1 795B3, B3-4602, R1 883A3, A3-3665

40.1.1 – Magnetic Resonance Angiography Coverage Summary

(Rev. 1, 10-01-03)

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

Because the status codes for HCPCS codes 71555, 71555-TC, 71555-26, 74185, 74185-TC, and 74185-26 were changed in the MPFSDB from N to R on April 1, 1998, any MRA claims with those HCPCS codes with dates of service between April 1, 1998, and June 30, 1999, are to be processed according to the contractor's discretionary authority to determine payment in the absence of national policy.

40.1.2 HCPCS Coding Requirements

(Rev. 1, 10-01-03)

Providers must report HCPCS codes when submitting claims for MRA of the chest, abdomen, head, neck or peripheral vessels of lower extremities. The following HCPCS codes should be used to report these services:

MRA of head	70544, 70544-26, 70544-TC
MRA of head	70545, 70545-26, 70545-TC
MRA of head	70546, 70546-26, 70546-TC
MRA of neck	70547, 70547-26, 70547-TC
MRA of neck	70548, 70548-26, 70548-TC
MRA of neck	70549, 70549-26, 70549-TC
MRA of chest	71555, 71555-26, 71555-TC

MRA of pelvis	72198, 72198-26, 72198-TC
MRA of abdomen (dates of service on or after July 1, 2003) – see below.	74185, 74185-26, 74185-TC
MRA of peripheral vessels of lower extremities	73725, 73725-26, 73725-TC

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

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

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

- MRA, pelvis, with or without contrast material(s) 72198, 72198-26, 72198-TC

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

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

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

40.1.3 - Special Billing Instructions for RHCs and FQHCs

(Rev. 1, 10-01-03)

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

The technical component for a provider based RHC/FQHC is typically furnished by the provider. The provider of that service bills under bill type, 13X, 14X, or 85X as appropriate using its outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services.)

40.1.4 – Payment Requirements

(Rev. 1, 10-01-03)

Payment is as follows:

- Inpatient – PPS, based on the DRG
- Hospital outpatient departments – OPPS, based on the APC
- Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs) – All-inclusive rate, professional component only, based on the visit furnished to the RHC/FQHC beneficiary to receive the MRA. The technical component is outside the scope of the RHC/FQHC benefit. Therefore the provider of the technical service bill their carrier on Form CMS-1500 and payment is made under MPFS.
- Critical Access Hospital (CAH) –
    - For CAHs that elected the optional method of payment for outpatient services, the payment for technical services would be the same as the CAHs that did not elect the optional method - Reasonable cost.
    - Carrier pays professional component at 115 percent of Medicare Physician Fee Schedule (MPFS).

Deductible and coinsurance apply.

50 - Nuclear Medicine (CPT 78000 - 79999)

(Rev. 1, 10-01-03)

50.1 - Payments for Radionuclides

(Rev. 1, 10-01-03)

The TC RVUs for nuclear medicine procedures (CPT codes 78XXX for diagnostic nuclear medicine, and codes 79XXX for therapeutic nuclear medicine) do not include the radionuclide used in connection with the procedure. These substances are separately billed under codes A4641 and A4642 for diagnostic procedures, and code 79900 for therapeutic procedures and are paid on a “By Report” basis depending on the substance used. In addition, CPT code 79900 is separately payable in connection with certain clinical brachytherapy procedures. (See §70.4 for brachytherapy procedures).

50.2 - Stressing Agent

(Rev. 1, 10-01-03)

Carriers must make separate payment under code J1245 for pharmacologic stressing agents used in connection with nuclear medicine and cardiovascular stress testing procedures furnished to beneficiaries in settings in which TCs are payable. Such an agent is classified as a supply and covered as an integral part of the diagnostic test. However, carriers pay for code J1245 under the policy for determining payments for "incident to" drugs. See Chapter 17 for payment for drugs.

50.2.1 - FI Payment for IV Persantine

(Rev. 1, 10-01-03)

SNF-533.1.I

FIs pay drug IV Persantine based on the drug pricing methodology when used in conjunction with nuclear medicine and cardiovascular stress testing procedures furnished to SNF outpatients. Separate drug pricing methodology payments for IV Persantine is made in addition to payments made for the procedure. SNFs bill HCPCS code J1245 (injection, dipyridamole, per 10 mg.) with revenue code 0636.

50.2.2 - FI Payment for Adenosine

(Rev. 1, 10-01-03)

SNF-533.3

The drug adenosine is paid based on the drug payment methodology when used as a pharmacologic stressor for other diagnostic testing. Separate based payment for adenosine will be made in addition to payments made for the procedure for SNF Part B patients. When billing for adenosine, HCPCS code J0150 (Injection, adenosine, 6 mg.) should be reported with revenue code 0636.

50.3 - Application of Multiple Procedure Policy (CPT Modifier "-51")

(Rev. 1, 10-01-03)

Carriers must apply the multiple procedure reduction to the following nuclear medicine diagnostic procedures: codes 78306, 78320, 78802, 78803, 78806, and 78807.

50.4 - Generation and Interpretation of Automated Data

(Rev. 1, 10-01-03)

Payment for CPT codes 78890 and 78891 is bundled into payments for the primary procedure.

60 - Positron Emission Tomography (PET) Scans

(Rev. 1, 10-01-03)

SNF-533.2, AB-02-115

Positron emission tomography (PET) is a noninvasive imaging procedure that assesses perfusion and the level of metabolic activity in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images by detecting radioactivity from a radioactive tracer substance (radiopharmaceutical) that is administered intravenously into the patient.

For dates of service on and after March 14, 1995, Medicare covers one use of PET scans, i.e., imaging of the perfusion of the heart using Rubidium 82 (Rb 82), provided that the following conditions are met:

- The PET is done at a PET imaging center with a PET scanner that has been approved by the FDA;

- The PET scan is a rest alone or rest with pharmacologic stress PET scan, used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease, using Rb 82; and

- Either the PET scan is used in place of, but not in addition to, a single photon emission computed tomography (SPECT) or the PET scan is used following a SPECT that was found inconclusive.

(HCPCS Codes G0030 -G0047, G0210-G0234, G0252-G0254, 78454) - For procedures furnished on or after March 14, 1995, carriers pay for PET procedure of the heart under the limited coverage policy above and set forth in the Medicare National Coverage Determinations Manual.

The Medicare National Coverage Determinations Manual contains additional coverage instructions to indicate the conditions under which a PET scan is performed. FIs process claims for the technical component with HCPCS codes under Revenue Code 0404 (Positron Emission Tomography).

HCPCS	Definition
G0030	PET myocardial perfusion imaging, (following previous PET, G0030-G0047); single study, rest or stress (exercise and/or pharmacologic)
G0031	PET myocardial perfusion imaging, (following previous PET, G0030-G0047); multiple studies, rest or stress (exercise and/or pharmacologic)

HCPCS	Definition
G0032	PET myocardial perfusion imaging, (following rest SPECT, 78464); single study, rest or stress (exercise and/or pharmacologic)
G0033	PET myocardial perfusion imaging, (following rest SPECT, 78464); multiple studies, rest or stress (exercise and/or pharmacologic)
G0034	PET myocardial perfusion imaging, (following stress SPECT, 78465); single study, rest or stress (exercise and/or pharmacologic)
G0035	PET myocardial perfusion imaging, (following stress SPECT, 78465); multiple studies, rest or stress (exercise and/or pharmacologic)
G0036	PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); single study, rest or stress (exercise and/or pharmacologic)
G0037	PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); multiple studies, rest or stress (exercise and/or pharmacologic)
G0038	PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460; single study, rest or stress (exercise and/or pharmacologic)
G0039	PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460; multiple studies, rest or stress (exercise and/or pharmacologic)
G0040	PET myocardial perfusion imaging, (following stress echocardiogram, 93350); single study, rest or stress (exercise and/or pharmacologic)
G0041	PET myocardial perfusion imaging, (following stress echocardiogram, 93350); multiple studies, rest or stress (exercise and/or pharmacologic)
G0042	PET myocardial perfusion imaging, (following stress nuclear ventriculogram, 78481 or 78483); single study, rest or stress (exercise and/or pharmacologic)
G0043	PET myocardial perfusion imaging, (following stress nuclear ventriculogram 78481 or 78483); multiple studies, rest or stress (exercise and/or pharmacologic)
G0044	PET myocardial perfusion imaging, (following rest ECG, 93000); single study, rest or stress (exercise and/or pharmacologic)

HCPCS	Definition
G0045	PET myocardial perfusion imaging, (following rest ECG, 93000); multiple studies, rest or stress (exercise and/or pharmacologic)
G0046	PET myocardial perfusion imaging, (following stress ECG, 93015); single study, rest or stress (exercise and/or pharmacologic)
G0047	PET myocardial perfusion imaging, (following stress ECG, 93015); multiple studies, rest or stress (exercise and/or pharmacologic)

Effective July 1, 1999, Medicare expanded coverage of PET scans to include the evaluation of recurrent colorectal cancer in patients with rising levels of carinoembryonic antigen (CEA), for the staging of lymphoma (both Hodgkins and non-Hodgkins) when the PET scan substitutes for a gallium scan or lymphangiogram, and for the staging of recurrent melanoma prior to surgery, provided certain conditions are met. All three indications are covered only when using the radiopharmaceutical FDA (2-[flourine-18]-fluoro-2-deoxy-D-glucose), and are further predicated on the legal availability of FDG for use in such scans.

HCPCS codes for PET scans when performed on or after July 1, 1999, are listed below.

HCPCS	Definition
G0163	Code deleted effective 6-30-2001. Position Emission tomography (PET), whole body, for recurrence of colorectal metastatic cancer
G0215	Code effective 1-1-2002. PET imaging whole body, full and partial ring PET scanners only, restaging colorectal cancer (replaces code G0163)
G0164	Code deleted effective 6-30-01. Position emission Tomography (PET), whole body, for staging and characterization of lymphoma.
G0221	Code effective 1-1-2002. Positron Emission Tomography (PET), imaging whole body, initial staging; lymphoma (replaces code G0164).
G0222	Code effective 1-1-2002. PET imaging whole body; restaging; lymphoma (replaces G0164)
G0165	Code deleted effective 6-30-01. Position Emission Tomography (PET), whole body, for recurrence of melanoma or melanoma metastatic cancer
G0218	Code effective 1-1-2002. PET imaging whole body, restaging; melanoma (replaces code G0165)

FIs pay these codes based on the technical component of the fee schedule when billed by SNFs. They are reported to FIs with revenue code 0404 (Positron Emission Tomography).

60.1 - Expanded Coverage of PET Scans for Claims With Dates of Service on or After July 1, 2002

(Rev. 1, 10-01-03)

AB-02-115

Effective for claims received on or after July 1, 2001, CMS will no longer require the designation of the four PET Scan modifiers (N, E, P, S) and that no paper documentation needs to be submitted up front with PET scan claims. Documentation requirements such as physician referral and medical necessity determination are to be maintained by the provider as part of the beneficiary's medical record. This information must be made available to the carrier or FI upon request of additional documentation to determine appropriate payment of an individual claim.

See the Medicare National Coverage Determinations Manual for specific coverage criteria for PET Scans. Coverage is expanded for PET scans to include the following effective July 1, 2001:

- Scans performed with dedicated full-ring scanners will be covered. Gamma camera systems with at least a 1 inch thick crystal are eligible for coverage in addition to those already approved by CMS (FDA approved);

- The provider must maintain on file the doctor's referral and documentation that the procedure involved:

    a. Only FDA approved drugs and devices and,

    b. Did not involve investigational drugs, or procedures using investigational drugs, as determined by the FDA;

- The ordering physician is responsible for certifying the medical necessity of the study according to the conditions. The physician must have documentation in the beneficiary's medical record to support the referral supplied to the PET scan provider;

The following is a brief summary of the expanded coverage.

- PET is covered for diagnosis, initial staging and restaging of non-small cell lung cancer (NSCLC).

- Usage of PET for colorectal cancer has been expanded to include diagnosis, staging, and restaging.

- Usage of PET for the initial staging, and restaging of both Hodgkin's and non-Hodgkin's disease.

- Usage of PET for the diagnosis, initial staging, and restaging of melanoma. **(PET Scans are NOT covered for the evaluation of regional nodes.)**

- Medicare covers PET for the diagnosis, initial staging, and restaging of esophageal cancer.

- Usage of PET for Head and Neck Cancers. **(PET scans for head and neck cancer is NOT covered for central nervous system or thyroid cancers.)**

- Usage of PET following an inconclusive single photon emission computed tomography (SPECT) only for myocardial viability. In the event that a patient has received a SPECT and the physician finds the results to be inconclusive, only then may a PET scan be ordered utilizing the proper documentation.

- Usage of PET for pre-surgical evaluation for patients with refractory seizures.

A - Limitations

For staging and restaging: PET is covered in either/or both of the following circumstances:

- The stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound); and/or

- The clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific symptoms). Use of PET to monitor tumor response during the planned course of therapy (i.e. when no change in therapy is being contemplated) is not covered

B - Frequency

In the absence of national frequency limitations, for all indications covered on and after July 1, 2001, contractors can, if necessary, develop frequency limitations on any or all covered PET scan services.

C - HCPCS for PET Scans

G0210 through G0230 are new HCPCS codes effective for claims with dates of service on and after July 1, 2001. Note that G0211 replaces G0126. HCPCS G0215 replaces G0163. HCPCS G0218 replaces code G0165. HCPCS G0221 and G0222 replace G0164. HCPCS G0219 is for noncovered indications.

D - Carrier Claims

Claims for PET scan services must be billed on the Form-CMS 1500 or the electronic equivalent with the appropriate HCPCS and diagnosis codes to the carrier. **Effective for claims received on or after July 1, 2001, PET modifiers will be discontinued and are no longer a claims processing requirement for PET scan claims.** Therefore, July 1, 2001, and after the MSN messages regarding the use of PET modifiers can be discontinued. The type of service (TOS) for the new PET scan procedure codes is TOS 4, Diagnostic Radiology.

E - FI Claims

Claims for PET scan procedures must be billed to the FI on Form CMS-1450 (UB-92) or the electronic equivalent with the appropriate diagnosis, HCPCS "G" codes to indicate the conditions under which a PET scan was done. These codes represent the technical component costs associated with these procedures when furnished to hospital and SNF outpatients. They are paid under the Outpatient Prospective Payment System to hospitals and under the Medicare Physician Fee schedule when billed by a SNF. Institutional providers bill these codes under Revenue Code 0404 (PET scan).

60.2 - Expanded Coverage of PET Scans for Claims with Dates of Service on or After October 1, 2002

(Rev. 1, 10-01-03)

AB-02-065

Effective for dates of service on or after October 1, 2002, Medicare will cover FDG PET as an adjunct to other imaging modalities for staging and restaging for locoregional, recurrence or metastasis. Monitoring treatment of a locally advanced breast cancer tumor and metastatic breast cancer when a change in therapy is contemplated is also covered as an adjunct to other imaging modalities. The baseline PET study for monitoring should be done under the code for staging or restaging.

Effective for dates of service on or after October 1, 2002, Medicare continues to have a national non-coverage determination for initial diagnosis of breast cancer and initial staging of axillary lymph nodes. Medicare coverage now includes PET as an adjunct to standard imaging modalities for staging patients with distant metastasis or restaging patients with locoregional recurrence or metastasis; as an adjunct to standard imaging

modalities for monitoring for women with locally advanced and metastatic breast cancer when a change in therapy is contemplated.

In the absence of national frequency limitations, contractors can, if necessary, develop reasonable frequency limitations for breast cancer.

A - HCPCS Codes for Breast Cancer PET Scans Performed on or After October 1, 2002

G0252 through G0254 are applicable codes for billing breast cancer PET scans performed on or after October 1, 2002.

B - HCPCS Codes for Myocardial Viability PET Scans Performed on or After October 1, 2002

G0230, 78459 are applicable for myocardial viability PET scans performed on or after October 1, 2002.

NOTE: The National Coverage Determinations Manual contains a description of coverage. FDG Positron Emission Tomography is a minimally invasive diagnostic procedure using positron camera [tomograph] to measure the decay of radioisotopes such as FDG. The CMS determined that the benefit category for the requested indications fell under §1861(s)(3) of the Act diagnostic service.)

C - Billing and Payment Requirements

FI claims for PET scan procedures must be billed on Form CMS-1450 (UB-92) or the electronic equivalent with the appropriate diagnosis HCPCS "G" codes to indicate the conditions under which a PET scan was done. These codes represent the technical component costs associated with these procedures when furnished to hospital outpatients, and are paid under the Outpatient Prospective Payment System. Providers bill these codes under Revenue Code 0404 (PET scan). Applicable bill types include: 12X, 13X, 21X, 22X, 23X, and 85X.

Payment pricing information for HCPCS codes are effective October 2002, in the Medicare Physician Fee Schedule.

60.2.1 - Coverage for Myocardial Viability

(Rev. 1, 10-01-03)

AB-02-065

FDG PET is covered for the determination of myocardial viability following an inconclusive single photon computed tomography test (SPECT) from July 1, 2001, through September 30, 2002. Only full ring scanners are covered as the scanning medium for this service from July 1, 2001, through December 31, 2001. However, as of

January 1, 2002, full and partial ring scanners are covered for myocardial viability following an inconclusive SPECT.

Beginning October 1, 2002, Medicare will cover FDG PET for the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization, and will continue to cover FDG PET when used as a follow-up to an inconclusive SPECT. However, if a patient received a FDG PET study with inconclusive results, a follow-up SPECT is not covered. FDA full and partial ring PET scanners are covered.

In the event that a patient receives a SPECT with inconclusive results, a PET scan may be performed and covered by Medicare. However, a SPECT is not covered following a FDG PET with inconclusive results. See the Medicare National Coverage Determinations Manual for specific frequency limitations for Myocardial Viability following an inconclusive SPECT.

In the absence of national frequency limitations, contractors can, if necessary develop reasonable frequency limitations for myocardial viability.

Documentation that these conditions are met should be maintained by the referring physician as part of the beneficiary's medical record.

60.3 - FI Post-Payment Review

(Rev. 1, 10-01-03)

As with any claim, but particularly in view of the limitations on this coverage, Medicare may decide to conduct post-payment reviews to determine that the use of PET scans is consistent with coverage instructions. SNFs must keep patient record information on file for each Medicare patient for whom a PET scan claim is made. These medical records will be used in any post-payment reviews and must include the information necessary to substantiate the need for the PET scan. These records must include standard information (e.g., age, sex, and height) along with sufficient patient histories to allow determination that the steps required in the coverage instructions were followed. Such information must include, but is not limited to, the date, place and results of previous diagnostic tests (e.g., cytopathology and surgical pathology reports, CT), as well as the results and reports of the PET scan(s) performed at the center. If available, such records should include the prognosis derived from the PET scan, together with information regarding the physician or institution to which the patient proceeded following the scan for treatment or evaluation. The ordering physician is responsible for forwarding appropriate clinical data to the PET scan facility.

60.4 - Use of Gamma Cameras and Full Ring and Partial Ring PET Scanners for PET Scans

(Rev. 1, 10-01-03)

AB-01-168

See the Medicare National Coverage Determinations Manual concerning 2-[F-18] Fluoro-D-Glucose (FDG) PET scanners and details about coverage.

On July 1, 2001, HCPCS codes G0210 - G0230 were added to allow billing for all currently covered indications for FDG PET. Although the codes do not indicate the type of PET scanner, these codes should be used until January 1, 2002, by providers to bill for services in a manner consistent with the coverage policy. Effective January 1, 2002, these codes have new descriptors to properly reflect the type of PET scanner used. Also effective January 1, 2002, there are four new G codes for covered conditions that may be billed if a gamma camera is used for the PET scan. As of January 1, 2002, providers should bill using the revised HCPCS codes G0120 - G0234. Payment is based on the Medicare Fee Schedule.

70 - Radiation Oncology (Therapeutic Radiology)

(Rev. 1, 10-01-03)

70.1 - Weekly Radiation Therapy Management (CPT 77419 - 77430)

(Rev. 1, 10-01-03)

Carriers must pay for a physician's weekly treatment management services under code 77427. Billing entities must indicate on each claim the number of fractions for which payment is sought.

A weekly unit of treatment management is equal to five fractions or treatment sessions. A week for the purpose of making payments under these codes is comprised of five fractions regardless of the actual time period in which the services are furnished. It is not necessary that the radiation therapist personally examine the patient during each fraction for the weekly treatment management code to be payable. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. If, at the final billing of the treatment course, there are three or four fractions beyond a multiple of five, those three or four fractions are paid for as a week. If there are one or two fractions beyond a multiple of five, payment for these services is considered as having been made through prior payments.

EXAMPLE: 18 fractions = 4 weekly services

62 fractions = 12 weekly services

8 fractions = 2 weekly services

6 fractions = 1 weekly service

If billings have occurred which indicate that the treatment course has ended (and, therefore, the number of residual fractions has been determined), but treatments resume, adjust carrier payments for the additional services consistent with the above policy.

EXAMPLE: 8 fractions = payment for 2 weeks

2 additional fractions are furnished by the same physician. No additional Medicare payment is made for the 2 additional fractions.

A - SNF Treatment Management Delivery Services

A SNF may not bill weekly treatment management services for its outpatients (codes 77419, 77420, 77425, 77430, and 77431). Instead, the SNF should bill for radiation treatment delivery (codes 77401 - 77404, 77406 - 77409, 77411 - 77414, and 77416). Also, SNFs bill for therapeutic radiology port film (code 77417), which was previously a part of the weekly services. They enter the number of services in the units field.

70.2 - Services Bundled Into Treatment Management Codes

(Rev. 1, 10-01-03)

Carriers do not make separate payment for services rendered by the radiation oncologists or in conjunction with radiation therapy.

11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin; 6.0 sq. cm or less
11921	6.1 to 20.0 sq. cm
11922	Each additional 20.0 sq. cm
16000	Initial treatment, first-degree burn, when no more than local treatment is required
16010	Dressings and/or debridement, initial or subsequent; under anesthesia, small
16015	Under anesthesia, medium or large, or with major debridement
16020	Without anesthesia, office or hospital, small

16025	Without anesthesia, medium (e.g., whole face or whole extremity)
16030	Without anesthesia, large (e.g., more than one extremity)
36425	Venipuncture, cut down age 1 or over
53670	Catheterization, urethra; simple
53675	Complicated (may include difficult removal of balloon catheter)
99211	Office or other outpatient visit, established patient; Level I
99212	Level II
99213	Level III
99214	Level IV
99215	Level V
99238	Hospital discharge day management
99281	Emergency department visit, new or established patient; Level I
99282	Level II
99283	Level III
99284	Level IV
99285	Level V
90780	IV Infusion therapy, administered by physician or under direct supervision of physician; up to one hour
90781	Each additional hour, up to 8 hours
90847	Family medical psychotherapy (conjoint psychotherapy) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated
99050	Services requested after office hours in addition to basic service
99052	Services requested between 10:00 PM and 8:00 AM in addition to basic service
99054	Services requested on Sundays and holidays in addition to basic service

99058 Office services provided on an emergency basis

99071 Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician

99090 Analysis of information data stored in computers (e.g., ECG, blood pressures, hematologic data)

99185 Hypothermia; regional

99371 Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals; simple or brief (e.g., to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy)

99372 Intermediate (e.g., to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate a new plan of care)

99373 Complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services or several different health professionals working on different aspects of the total patient care plan)

- Anesthesia (whatever code billed)
- Care of Infected Skin (whatever code billed)
- Checking of Treatment Charts
- Verification of Dosage, As Needed (whatever code billed)
- Continued Patient Evaluation, Examination, Written Progress Notes, As Needed (whatever code billed)
- Final Physical Examination (whatever code billed)
- Medical Prescription Writing (whatever code billed
- Nutritional Counseling (whatever code billed)
- Pain Management (whatever code billed)

- Review & Revision of Treatment Plan (whatever code billed)
- Routine Medical Management of Unrelated Problem (whatever code billed)
- Special Care of Ostomy (whatever code billed)
- Written Reports, Progress Note (whatever code billed)
- Follow-up Examination and Care for 90 Days After Last Treatment (whatever code billed)

70.3 - Radiation Treatment Delivery (CPT 77401 - 77417)

(Rev. 1, 10-01-03)

Carriers pay for these TC services on a daily basis under CPT codes 77401-77416 for radiation treatment delivery. They do not use local codes and RVUs in paying for the TC of radiation oncology services. Multiple treatment sessions on the same day are payable as long as there has been a distinct break in therapy services, and the individual sessions are of the character usually furnished on different days. Carriers pay for CPT code 77417 (Therapeutic radiology port film(s)) on a weekly (five fractions) basis.

70.4 - Clinical Brachytherapy (CPT Codes 77750 - 77799)

(Rev. 1, 10-01-03)

Carriers must apply the bundled services policy to procedures in this family of codes other than CPT code 77776. For procedures furnished in settings in which TC payments are made, carriers must pay separately for the expendable source associated with these procedures under CPT code 79900 except in the case of remote after-loading high intensity brachytherapy procedures (CPT codes 77781-77784). In the four codes cited, the expendable source is included in the RVUs for the TC of the procedures.

70.5 - Radiation Physics Services (CPT Codes 77300 - 77399)

(Rev. 1, 10-01-03)

Carriers pay for the PC and TC of CPT codes 77300-77334 and 77399 on the same basis as they pay for radiologic services generally. For professional component billings in all settings, carriers presume that the radiologist participated in the provision of the service, e.g., reviewed/validated the physicist's calculation. CPT codes 77336 and 77370 are technical services only codes that are payable by carriers in settings in which only technical component is are payable.

80 - Supervision and Interpretation (S&I) Codes and Interventional Radiology

(Rev. 1, 10-01-03)

80.1 - Physician Presence

(Rev. 1, 10-01-03)

Radiologic supervision and interpretation (S&I) codes are used to describe the personal supervision of the performance of the radiologic portion of a procedure by one or more physicians and the interpretation of the findings. In order to bill for the supervision aspect of the procedure, the physician must be present during its performance. This kind of personal supervision of the performance of the procedure is a service to an individual beneficiary and differs from the type of general supervision of the radiologic procedures performed in a hospital for which FIs pay the costs as physician services to the hospital. The interpretation of the procedure may be performed later by another physician. In situations in which a cardiologist, for example, bills for the supervision (the "S") of the S&I code, and a radiologist bills for the interpretation (the "I") of the code, both physicians should use a "-52" modifier indicating a reduced service, e.g., only one of supervision and/or interpretation. Payment for the fragmented S&I code is no more than if a single physician furnished both aspects of the procedure.

80.2 - Multiple Procedure Reduction

(Rev. 1, 10-01-03)

Carriers make no multiple procedure reductions in the S&I or primary non-radiologic codes in these types of procedures, or in any procedure codes for which the descriptor and RVUs reflect a multiple service reduction. For additional procedure codes that do not reflect such a reduction, carriers apply the multiple procedure reductions.

90 - Services of Portable X-Ray Suppliers

(Rev. 1, 10-01-03)

B3-2070.4, B3-15022.G, B3-4131, B3-4831

Services furnished by portable x-ray suppliers may have as many as four components. Carriers must follow the following rules.

90.1 - Professional Component

(Rev. 1, 10-01-03)

Pay the PC of radiologic services furnished by portable x-ray suppliers on the same basis as other physician fee schedule services.

90.2 - Technical Component

(Rev. 1, 10-01-03)

Pay the TC of radiology services furnished by portable x-ray suppliers under the fee schedule on the same basis as TC services generally.

90.3 - Transportation Component (HCPCS Codes R0070 - R0076)

(Rev. 1, 10-01-03)

B-03-049

This component represents the transportation of the equipment to the patient. Establish local RVUs for the transportation R codes based on carrier knowledge of the nature of the service furnished. Carriers may allow only a single transportation payment for each trip the portable x-ray supplier makes to a particular location. When more than one Medicare patient is x-rayed at the same location, e.g., a nursing home, prorate the single fee schedule transportation payment among all patients receiving the services. For example, if two patients at the same location receive x-rays, make one-half of the transportation payment for each.

Carriers must use any information regarding the number of patients x-rayed in each location that the supplier visits during each trip that the supplier of the x-ray may volunteer on the bill or claim for payment. If such information is not indicated, they assume that at least four patients were x-rayed at the same location, and pay only one-fourth of the fee schedule payment amount for any one patient. Carriers must advise the suppliers in their area regarding the way in which they use this information.

As a carrier priced service, carriers must initially determine a payment rate for portable x-ray transportation services that is associated with the cost of providing the service. In order to determine an appropriate cost, the carrier should, at a minimum, cost out the vehicle, vehicle modifications, gasoline and the staff time involved in only the transportation for a portable x-ray service. A review of the pricing of this service should be done every five years.

Direct costs related to the vehicle carrying the x-ray machine are fully allocable to determining the payment rate. This includes the cost of the vehicle using a recognized depreciation method, the salary and fringe benefits associated with the staff who drive the vehicle, the communication equipment used between the vehicle and the home office, the salary and fringe benefits of the staff who determine the vehicles route (this could be proportional of office staff), repairs and maintenance of the vehicle(s), insurance for the vehicle(s), operating expenses for the vehicles and any other reasonable costs associated with this service as determined by the carrier. The carrier will have discretion for allocating indirect costs (those costs that cannot be directly attributed to portable x-ray transportation) between the transportation service and the technical component of the x-ray tests.

Suppliers may send carriers unsolicited cost information. The carrier may use this cost data as a comparison to its carrier priced determination. The data supplied should reflect a year's worth (either calendar or corporate fiscal) of information. Each provider who submits such data is to be informed that the data is subject to verification and will be used to supplement other information that is used to determine Medicare's payment rate.

Carriers are required to update the rate on an annual basis using independently determined measures of the cost of providing the service. A number of readily available measures (e.g., ambulance inflation factor, the Medicare economic index) that are used by the Medicare program to adjust payment rates for other types of services may be appropriate to use to update the rate for years that the carrier does not recalibrate the payment. Each carrier has the flexibility to identify the index it will use to update the rate. In addition, the carrier can consider locally identified factors that are measured independently of CMS as an adjunct to the annual adjustment.

NOTE: No transportation charge is payable unless the portable x-ray equipment used was actually transported to the location where the x-ray was taken. For example, carriers do not allow a transportation charge when the x-ray equipment is stored in a nursing home for use as needed. However, a set-up payment (see §90.4, below) is payable in such situations. Further, for services furnished on or after January 1, 1997, carriers may not make separate payment under HCPCS code R0076 for the transportation of EKG equipment by portable x-ray suppliers or any other entity.

90.4 - Set-Up Component (HCPCS Code Q0092)

(Rev. 1, 10-01-03)

Carriers must pay a set-up component for each radiologic procedure (other than retakes of the same procedure) during both single patient and multiple patient trips under Level II HCPCS code Q0092. Carriers do not make the set-up payment for EKG services furnished by the portable x-ray supplier.

90.5 - Transportation of Equipment Billed by a SNF to an FI

(Rev. 1, 10-01-03)

SNF 533.1.J

When a SNF transports portable x-ray equipment to a site by van or other vehicle, the SNF should bill for the transportation costs using one of the following HCPCS codes along with the appropriate revenue code:

R0070	Transportation of Portable x-ray Equipment and Personnel to Home or Nursing Home, Per Trip to Facility or Location, One Patient Seen.

R0075	Transportation of Portable x-ray Equipment and Personnel to Home or Nursing Home, Per Trip to Facility or Location, More than One Patient Seen, Per Patient.

These HCPCS codes are subject to the fee schedule.

100 - Interpretation of Diagnostic Tests

(Rev. 1, 10-01-03)

B3-15023

100.1 - X-rays and EKGs Furnished to Emergency Room Patients

(Rev. 1, 10-01-03)

The professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and written report for inclusion in the beneficiary's medical record maintained by the hospital. (See 42 CFR 415.120(a).)

Carriers generally distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. This is because the review is already included in the emergency department evaluation and management (E/M) payment. For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available).

Generally, carriers must pay for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. They pay for a second interpretation (which may be identified through the use of modifier "-77") only under unusual circumstances (for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure.

When carriers receive only one claim for an interpretation, they must presume that the one service billed was a service to the individual beneficiary rather than a quality control measure and pay the claim if it otherwise meets any applicable reasonable and necessary test.

When carriers receive multiple claims for the same interpretation, they must generally pay for the first bill received. Carriers must pay for the interpretation and report that

directly contributed to the diagnosis and treatment of the individual patient. Consideration is not given to physician specialty as the primary factor in deciding which interpretation and report to pay regardless of when the service is performed. Consideration is not given to designation as the hospital's "official interpretation" as a factor in determining which claim to pay. Carriers pay for the interpretation billed by the cardiologist or radiologist if the interpretation of the procedure is performed at the same time as the diagnosis and treatment of the beneficiary. (This interpretation may be an oral report to the treating physician that will be written at a later time.)

If the first claim received is from a radiologist, carriers generally pay the claim because they would not know in advance that a second claim would be forthcoming. When carriers receive the claim from the emergency room (ER) physician and can identify that the two claims are for the same interpretation, they must determine whether the claim from the ER physician was the interpretation that contributed to the diagnosis and treatment of the patient and, if so, they pay that claim. In such cases, carriers must determine that the radiologist's claim was actually quality control and institute recovery action.

The two parties should reach an accommodation about who should bill for these interpretations. The following examples apply to carriers:

EXAMPLE A

A physician sees a beneficiary in the ER on January 1 and orders a single view chest x-ray. The physician reviews the x-ray, treats, and discharges the beneficiary. A carrier receives a claim from a radiologist for CPT code 71010-26 indicating an interpretation with written report with a date of service of January 3. The carrier will pay the radiologist's claim as the first bill received. Carriers do not have to develop the claim to determine whether the interpretation was a quality control service.

EXAMPLE B

Same circumstances as Example A, except that the physician who sees the beneficiary in the ER also bills for CPT code 71010-26 with a date of service of January 1. The carrier will pay the first claim received. If the first claim is from the treating physician in the ER, and there is no indication the claim should not be paid, e.g., no reason to think that a complete, written interpretation has not been performed, payment of the claim is appropriate. The carrier will deny a claim subsequently received from a radiologist for the same interpretation as a quality control service to the hospital rather than a service to the individual beneficiary.

EXAMPLE C

Same as Example B except that the claim from the radiologist uses modifier "-77" and indicates that, while the ER physician's finding that the patient did not have pneumonia was correct, there was also a suspicious area of the lung suggesting a tumor that required further testing. In such situations, the carrier pays for both claims under the fee schedule.

EXAMPLE D

The carrier receives separate claims for CPT code 71010-26 from a radiologist and a physician who treated that patient in the ER, both with a date of service of January 1. The first claim processed in the system is paid and the second claims will be identified and denied as a duplicate. If the denied "provider" is the radiologist and he raises an issue the carrier will develop the claim to determine whether the findings of the radiologist's interpretation were conveyed to the treating physician (orally or in writing) in time to contribute to the diagnosis and treatment of the patient. If the radiologist's interpretation was furnished in time to serve this purpose, that claim should be paid, and the claim from the other physician should be denied as not reasonable and necessary.

110 - Special Billing Instructions for Claims Submitted to FIs

(Rev. 1, 10-01-03)

Transmittal 368 (CR 1323 issued May 24-01) which revised the following SNF sections of the manual but not incorporated in the master manual.
SNF-533.1, SNF-533.1.A, SNF-533.1.B, SNF-533.1.C, SNF-533.1.D, SNF-533.1.E

For billing instructions, see Chapter 25.

110.1 - Aborted Procedure

(Rev. 1, 10-01-03)

When a procedure is not completed, the SNF should bill an unlisted code (e.g., CPT code ending in 99) and show the actual charges for the procedure. The FI will request additional data from the SNF to determine applicable payment. Deductible and coinsurance apply based on fee schedule rules.

110.2 - Combined Procedures (Radiology)

(Rev. 1, 10-01-03)

There are no separate codes covering certain combined procedures, e.g., a hand and forearm included in a single x-ray. The code with the higher fee schedule amount should be used.

110.3 - Payment for Radiopharmaceuticals

(Rev. 1, 10-01-03)

SNF-533.1.H

Radiopharmaceuticals are not subject to the fee schedule, but are paid based on reasonable cost when given in a SNF. SNFs report HCPCS codes 79900, A4641, A4642, A9500, A9503, and A9505, as appropriate, with revenue codes 0333, 034X, or 0636.

NOTE: The correct code to report is A4641. It replaced HCPCS code 78990. HCPCS code 78990 should not be reported because this code is not valid for Medicare purposes.

EXCEPTION: HCPCS codes 77781, 77782, 77783, and 77784 include payment for the radiopharmaceutical in the technical component. When these procedures are performed, SNFs do not report radiopharmaceutical codes 79900, A4641, A4642, A9500, A9503, and A9505. The FI will reject codes 79900, A4641, A4642, A9500, A9503, and A9505 when they are billed for supplies used in conjunction with procedure codes 77781, 77782, 77783, and 77784.

120 - Radiology or Other Diagnostic Unlisted Service or Procedure Billing Instructions for FI Claims

(Rev. 1, 10-01-03)

SNF-533.4

Some radiology and other diagnostic services may not have a corresponding HCPCS code. This is because these are typically services that are rarely provided, unusual, or new. The provider should assign the appropriate "unlisted procedure" code to any such service. The following list contains the "unlisted procedure" codes along with the suggested revenue code for billing. These services are paid on a fee schedule if one exists or cost if a fee has not been established for SNFs. However, before billing any of these codes the provider needs to furnish a complete description of the radiology procedure to the FI for review and analysis. The description should include a narrative definition of the procedure and a description of the nature, extent and need for the procedure and the time, effort, and equipment necessary. The FI will determine if the provider has correctly identified the procedure as "unlisted." If the procedure is not identified correctly, the FI will inform the provider of the correct HCPCS code to assign to the procedure. If there is no fee schedule amount established, these services are paid based on cost to SNFs.

For Radiology:

Revenue Code	HCPCS	Definition
032x	76499	Unlisted diagnostic radiologic procedure
0402	76999	Unlisted ultrasound procedure
0333	77299	Unlisted procedure, therapeutic radiology clinical treatment planning
0333	77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices

Revenue Code	HCPCS	Definition
0333	77499	Unlisted procedure, therapeutic radiology clinical treatment management
0333	77799	Unlisted procedure, clinical brachytherapy
034x	78099	Unlisted endocrine procedure, diagnostic nuclear medicine
034x	78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine
034x	78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine
034x	78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine
034x	78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine
034x	78599	Unlisted respiratory procedure, diagnostic nuclear medicine
034x	78699	Unlisted nervous system procedure, diagnostic nuclear medicine
034x	78799	Unlisted genitourinary procedure, diagnostic nuclear medicine
034x	78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine
034x	79999	Unlisted radiopharmaceutical therapeutic procedure

For Other Diagnostic Procedures:

Revenue Code	HCPCS	Definition
075x	91299	Unlisted diagnostic gastroenterology procedure
047x	92599	Unlisted otorhinolaryngological service or procedure
048x	93799	Unlisted cardiovascular service or procedure
073x	93799	Unlisted cardiovascular service or procedure

Revenue Code	HCPCS	Definition
0921	93799	Unlisted cardiovascular service or procedure
046x	94799	Unlisted pulmonary service or procedure
074x	95999	Unlisted neurological or neuromuscular diagnostic procedure
0922	95999	Unlisted neurological or neuromuscular diagnostic procedure

130 - EMC Formats

(Rev. 1, 10-01-03)

Billing instructions for Form CMS-1450 and equivalent electronic formats can be found in Chapter 25. Each revenue code requires a HCPCS code, modifier if applicable, units, line-item date of service, and charge.

Billing instructions for Form CMS-1500 and equivalent electronic formats can be found in the Medicare Claims Processing Manual, 26, “Instructions for Completing Form CMS-1500, NSF, and related ANSI X12N formats."

140 - Bone Mass Measurements

(Rev. 1, 10-01-03)

SNF-533.5 B3-4181, A3-3631.n

Sections 1861(s)(15) and (rr)(1) of the Act (as added by §4106 of the Balanced Budget Act (BBA) of 1997) standardize Medicare coverage of medically necessary bone mass measurements by providing for uniform coverage under Medicare Part B. This coverage is effective for claims with dates of service furnished on or after July 1, l998.

140.1 - Conditions of Coverage

(Rev. 1, 10-01-03)

SNF-533.5.A, B3-4181.1, A3-3631.n

Medicare pays for a bone mass measurement that meets all of the following criteria:

1 - Is a radiologic or radioisotopic procedure or other procedure which:

- Is performed with a bone densitometer (other than dual photon absorptiometry (DPA)) or a bone sonometer (i.e., ultrasound) device approved or cleared for marketing by the Food and Drug Administration (FDA);

- Is performed for the purpose of identifying bone mass or detecting bone loss or determining bone quality; and

- Includes a physician's interpretation of the results of the procedure.

2 - Is performed on a qualified individual. The term "qualified individual" means a Medicare beneficiary who meets the medical indications for at least one of the five categories listed below:

- A woman who has been determined by the physician or a qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings;

- An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture;

- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 7.5 mg of prednisone, or greater, per day, for more than three months;

- An individual with primary hyperparathyroidism; or

- An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.

3 - Is ordered by the individual's physician or qualified nonphysician practitioner who is treating the beneficiary following an evaluation of the need for a measurement, including a determination as to the medically appropriate measurement to be used for the individual. A physician or qualified nonphysician practitioner treating the beneficiary for purposes of this provision is one who furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results in the management of the patient. For the purposes of the bone mass measurement benefit, qualified nonphysician practitioners include physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives.

4 - Is furnished by a qualified supplier or provider of such services under the appropriate level of supervision of a physician.

5 - Is reasonable and necessary for diagnosing, treating, or monitoring the condition of a "qualified individual" as that term is defined above.

6 - Is performed at a frequency that conforms to the requirements described below.

NOTE: Since not every woman who has been prescribed estrogen replacement therapy (ERT) may be receiving an "adequate" dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating nonphysician practitioner from ordering a bone mass measurement for her. If a bone mass measurement is ordered for a woman following a careful evaluation of her medical need,

however, it is expected that the ordering treating physician (or other qualified treating nonphysician practitioner) will document in her medical record why he or she believes that the woman is estrogen-deficient and at clinical risk for osteoporosis.

140.2 - Frequency Standard

(Rev. 1, 10-01-03)

SNF-533.5.B, B3-4181.2, A3-3631.n

Medicare pays for a bone mass measurement meeting the criteria as stated above once every two years (at least 23 months have passed since the month the last bone mass measurement was performed). However, if it is medically necessary, Medicare may pay for a bone mass measurement for a beneficiary more frequently than every two years. Examples of situations where more frequent bone mass measurement procedures may be medically necessary include, but are not limited to, the following medical circumstances:

- Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than three months; and

- Allowing for a confirmatory baseline bone mass measurement (either central or peripheral) to permit monitoring of beneficiaries in the future if the initial test was performed with a technique that is different from the proposed monitoring method (for example, if the initial test was performed using bone sonometry and monitoring is anticipated using bone densitometry, cover the baseline measurement using bone densitometry).

140.3 - Payment Methodology and HCPCS Coding

(Rev. 1, 10-01-03)

SNF-533.5.C, B3-4181.3, B3-4181.4, A3-3631.n

Carriers pay for bone mass measurement procedures based on the Medicare physician fee schedule. Claims from physicians, other practitioners, or suppliers where assignment was not taken are subject to the Medicare limiting charge.

FIs pay for bone mass measurement procedures under the current payment methodologies for radiology services according to the type of provider.

Deductible and coinsurance apply.

Any of the following codes may be used when billing for bone mass measurements. All of these codes are bone densitometry measurements except code 76977 which is bone sonometry measurements. Codes are applicable to billing FIs and carriers.

76075 76076 76078 76977 78350 G0130 G0131 G0132

FIs are billed using Form CMS-1450 or its electronic equivalent. The appropriate bill types are: 12X, 13X, 14X, 22X, 23X, 34X, 71X (Provider-based and independent), 72X, 73X (Provider-based and freestanding), 83X, and 85X.

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

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

Providers must report HCPCS codes for bone mass measurements under revenue code 320 with number of units and line item dates of service per revenue code line for each bone mass measurement reported.

Carriers are billed for bone mass measurement procedures using Form CMS-1500 or its electronic equivalent. Follow the general instructions for Medicare billing.