Medicare

Carriers Manual

Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 864

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter IV	4-4.3 - 4-4.5 (3 pp.)	4-4.3 - 4-4.5 (3 pp.)
4602.2 - 4602.3	4-431 - 4-432 (2 pp.)	4-431 (1 p.)

MANUALIZATION--EFFECTIVE DATE: Not Applicable
--IMPLEMENTATION DATE: Not Applicable

Section 4602, Magnetic Resonance Angiography, has been created in order to manualize Program Memorandum AB 99-34. This section provides billing and payment instructions for Medicare Part B claims for magnetic resonance angiography (MRA). Effective for dates of service on or after July 1, 1999, Medicare provides limited coverage for MRA of the abdomen and chest. Previously, MRA of peripheral vessels of the lower extremities and of the head and neck had been covered on a limited basis and continue to be so covered. These coverages are described in the Medicare Coverages Issues Manual, §50-14, "Magnetic Resonance Angiography".

Section 4602.1, Magnetic Resonance Angiography Coverage Summary, provides a brief general summary of the limited diagnostic coverage of magnetic resonance angiography under Medicare.

Section 4602.2, Coding Requirements, provides the appropriate HCPCS codes to be used when submitting claims for covered services.

Section 4602.3, Payment Requirements and Methodology, provides information concerning Medicare Part B deductible and coinsurance and the Medicare Limiting Charge.

Section 4602.4, Format for Submitting Medicare Carrier Claims, describes the appropriate HCFA form or electronic equivalent for submitting claims and the relevant claims instructions.

Section 4602.5, Claims Editing, describes the appropriate editing procedures to be employed by carriers.

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.

CHAPTER IV

Section

Immunosuppressive Drugs

Vaccines

Services Provided In Health Manpower Shortage Areas

HCFA Common Procedure Coding System (HCPCS)

CHAPTER IV

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4601.5 Remittance Advice Messages.--If the claim is denied because the beneficiary is under 35 years of age, use existing American National Standard Institute (ANSI) X-12-835 claim adjustment reason code/message 6, "The procedure is inconsistent with the patient's age" along with the line level remark code M37, "Service is not covered when the beneficiary is under age 35."

If the claim is denied for a woman 35-39 because she has previously received this examination, use existing ANSI X-12-835 claim adjustment reason code/message 119, "Benefit maximum for this time period has been reached" along with the line level remark code M89, "Not covered more than once under age 40."

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, using existing ANSI X-12-835 claim adjustment reason code/message 119, "Benefit maximum for this time period has been reached" along with the line level remark code M90, "Not covered more than once in a 12 month period."

If the claim is denied because the provider that performed the screening is not certified, use existing ANSI X-12-835 claim adjustment reason code/message B7, "This provider was not certified for this procedure/service on this date of service."

4602. MAGNETIC RESONANCE ANGIOGRAPHY

4602.1 Magnetic Resonance Angiography Coverage Summary--Section 1861(s)(2)(C) of the Social Security Act provides for coverage of diagnostic testing. Effective for services performed on or after July 1, 1999, Medicare provides limited coverage for magnetic resonance angiography (MRA) of the abdomen and chest. Previously, MRA of peripheral vessels of the lower extremities and MRA of the head and neck had been covered on a limited basis. These coverages are described in the Medicare Coverages Issues Manual, §50-14, "Magnetic Resonance Angiography". MRA is covered for those diagnostic applications only as a substitute for contrast angiography, except where it is medically necessary to do both tests. Medicare coverage of MRA is only extended when the service is reasonable and necessary. There is no coverage of MRA outside of the indications provided 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.

4602.2 Coding Requirements--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 and/or neck	70541, 70541-26, 70541-TC
MRA of chest	71555, 71555-26, 71555-TC
MRA of abdomen	74185, 74185-26, 74185-TC
MRA of peripheral vessels of lower extremities	73725, 73725-26, 73725-TC

4602.3 Payment Requirements and Methodology.--

- Medicare Part B deductible and coinsurance apply.
- Pay for MRAs undercurrent payment methodologies for radiology services.
- Claims where assignment was not taken are subject to the Medicare Limiting Charge (refer to MCM, Part 3, Chapter VII, §7555 for more information).
- Providers must report component services with -26(professional component) or -TC (technical component) modifier when appropriate. Physicians performing both the professional and technical components for such services must bill without the modifier unless the service is provided in a Health Professional Shortage Area.

4602.4 Format for Submitting Medicare Carrier Claims.--Claims for MRA are to be submitted on Health Insurance Claim Form HCFA-1500 or electronic equivalent. Follow the general instructions in §2010, Purpose of Health Insurance Claim Form HCFA-1500, Medicare Carriers Manual Part 4, Chapter 2.

4602.5 Claims Editing.--Nationwide claims processing edits for pre or post payment review of claim(s) for concurrent MRA and contrast angiography on the same beneficiary are not being required at this time. Carriers should monitor submission of claim(s) for concurrent MRA and contrast angiography and perform medical review as appropriate. Carriers may develop local medical review policy and edits for such claim(s).