
Medicare

Carriers Manual

Part 3 - Claims Process

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

Transmittal 1671

Date: JULY 13, 2000

CHANGE REQUEST 864

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
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.

HCFA-Pub. 14-3

CHAPTER IV

Section

Immunosuppressive Drugs

Payment for Immunosuppressive Drugs.....	4471
Routing Claims.....	4471.1
Determination of Eligibility.....	4471.2
Reasonable Charge Determinations.....	4471.3
HCPCS Codes.....	4471.4
EOMB Messages.....	4471.5
Carriers Reporting.....	4471.6
Exhibit 1 - Form HCFA 2745-U3.....	

Vaccines

Billing for Pneumococcal, Hepatitis B, and Influenza Virus Vaccines.....	4480
General Claims Processing Requirements.....	4480.1
HCPCS Coding.....	4480.2
Billing Requirements.....	4480.3
Payment Requirements.....	4480.4
No Legal Obligation to Pay.....	4480.5
Simplified Roster Bills.....	4480.6

Services Provided In Health Manpower Shortage Areas

Determining if a New Physician Provided Service in a Health Manpower Shortage Area.....	4500
List of Health Manpower Shortage Areas (HMSAs).....	4500.1
Calculating the Appropriate Customary Charge.....	4500.2
New Physician Billing for Services Performed in a HMSA.....	4500.3

HCFA Common Procedure Coding System (HCPCS)

HCFA Common Procedure Coding System (HCPCS).....	4501
Use and Maintenance of CPT-4 in HCPCS.....	4506
Local Codes.....	4507
Local Codes at Regular Carriers.....	4507.1
Use and Acceptance of HCPCS Codes and Modifiers.....	4508
HCPCS Update.....	4509
Payment Concerns While Updating Codes.....	4509.1
Payment Utilization Review (UR) and Coverage Information on HCFA Tape File.....	4509.2
Deleted HCPCS Codes/Modifiers.....	4509.3
Claims Review and Adjudication Procedures.....	4540
Professional Relations.....	4550
Professional Relations for HCPCS.....	4551
HCPCS Training.....	4552
Radiology Fee Schedule.....	4600
Mixed Multispecialty Clinic (Specialty Code 70).....	4600.1
Radiation Therapy.....	4600.2
Issue Conversion Factors to Intermediaries.....	4600.3
Screening Mammography.....	4601
Screening Mammography Examinations.....	4601.1
Identifying a Screening Mammography Claim.....	4601.2

CHAPTER IV

	<u>Section</u>
Adjudicating the Claim	4601.3
MSN and EOMB Messages	4601.4
Remittance Advice Messages	4601.5
Magnetic Resonance Angiography	4602
Magnetic Resonance Angiography Coverage Summary	4602.1
Coding Requirements	4602.2
Payment Requirements and Methodology	4602.3
Format for Submitting Medicare Carrier Claims	4602.4
Claims Editing	4602.5
Furnishing Medicare Physician Fee Schedule Database (MPFSDB) Pricing Files	4620
Furnishing Physician Fee Schedule Data for Local and Carrier Priced Codes	4620.1
Furnishing Physician Fee Schedule Data for National Codes	4620.2
Furnishing Fee Schedule (Excluding Physician Fee Schedule), Prevailing Charge and Conversion Factor Data to United Health Care, Intermediaries, State Agencies, Indian Health Services, and United Mine Workers	4620.3
File Specifications	4621
Correct Coding Initiative	4630

Submission of Claims to Medigap Insurers

Submission of Claims to Medigap Insurer	4700
General Requirements	4701
Completion of the Claim Form	4702
Medigap Assignment Selection	4702.1
EOMB Messages	4703
Remittance Notice Messages	4704
Returned Medigap Notices	4705
Charging Medigap Insurers	4706
Electronic Transmission	4707
Paper Submission	4708
Medigap Electronic Claims Transfer Agreements	4709

Global Surgery

General	4820
Definition of a Global Surgical Package	4821
Billing Requirements for Global Surgeries	4822
Claims Review for Global Surgeries	4823
Adjudication of Claims for Global Surgeries	4824
Postpayment Issues	4825
Claims for Multiple Surgeries	4826
Claims for Bilateral Surgeries	4827
Claims for Co- and Team Surgeons	4828
Procedures Billed with Two or More Surgical Modifiers	4829
Claims for Anesthesia Services Performed On or After January 1, 1992	4830
Billing for Portable X-Ray Set-Up Services	4831

National Emphysema Treatment Trial

National Emphysema Treatment Trial	4900
Background	4900.1
Coverage Summary	4900.2
Beneficiaries Participating in the Study	4900.3

CHAPTER IV

	<u>Section</u>
Sites of Service.....	4900.4
Format for Submitted Claims	4900.5
Identifying NETT Claims.....	4900.6
Bypassing Existing Edits in Your System.....	4900.7
Common Working File (CWF) Processing of NETT Claims	4900.8
Dates of Service	4900.9
Late Claim Submission.....	4900.10
Termination of a Beneficiary's Participation	4900.11
Coding	4900.12
Payment	4900.13
Managed Care	4900.14
Responding to Billing Questions	4900.15
Denied Claims	4900.16
Participating Clinical Centers.....	4900.17

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.--

- o Medicare Part B deductible and coinsurance apply.
- o Pay for MRAs undercurrent payment methodologies for radiology services.
- o Claims where assignment was not taken are subject to the Medicare Limiting Charge (refer to MCM, Part 3, Chapter VII, §7555 for more information).
- o 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).

4-432

Rev. 1671