Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 1795 **Date: MAY 9, 2003**

CHANGE REQUEST 2673

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4601.6 (Cont.) - 4602.3	4-430.3 – 4-430.4 (2 pp.)	4-430.3– 4-430.4 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2003*
IMPLEMENTATION DATE: July 1, 2003

Section 4602.1 Magnetic Resonance Angiography Coverage Summary, is revised to indicate the addition of limited coverage for magnetic resonance angiography of the pelvis.

Section 4602.2 Coding Requirements, is revised to update the HCPCS codes for magnetic resonance angiography of the head and neck and to add HCPCS codes for magnetic resonance angiography of the pelvis.

Carriers should publish these changes in their next regularly scheduled bulletins and post it on their Web sites within two weeks of receiving this transmittal.

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.

o HCPCS code G0203, Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. Payment will be equal to the lesser of the actual charge for the procedure. The amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or $57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the $15.00 add-on for 2001 which is provided under the new legislation). Part B deductible does not apply. Coinsurance is 20 percent of the charge.

o HCPCS code G0204, Diagnostic mammography, direct digital image, bilateral, all views. Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific amount paid under the physician fee schedule for the technical component (TC) of CPT code 76091, the code for a bilateral diagnostic mammogram.) Twenty percent of the lower of charge or 150 percent of MPFS. Deductible is applicable. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

o HCPCS code G0205, Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. Payment will be equal to the lesser of the actual charge for the procedure, the amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or $57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the $15.00 add-on for 2001 which is provided under the new legislation). Deductible applies. Coinsurance is 20 percent of the charge.

o HCPCS code G0206, Diagnostic mammography, direct digital image, unilateral, all views. Payment will be made based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (i.e., hospital, rural health clinic, etc.) for CPT code 76090, the code for a mammogram, one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount under the outpatient prospective payment system (OPPS) for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

o HCPCS code G0207, Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all view. Payment will be based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (i.e., hospital, rural health clinic) for CPT code 76090, the code for mammogram, one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount payable under the OPPS for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

NOTE: Codes G0203, G0205 and G0207 are not billable codes for claims with dates of service on or after January 1, 2002.

B. Billing Requirements.--Only one screening mammogram, either 76092 or G0202 may be billed in a calendar year. Therefore, advise your providers not to submit claims reflecting both a film screening mammography (76092) and a digital screening mammography G0202. Also advise your providers not to submit claims reflecting HCPCS codes 76090 or 76091 (diagnostic mammography-film) and G0204 or G0206 (diagnostic mammography-digital). Deny the claim when both a film and digital screening or diagnostic mammography are reported. However, a screening and diagnostic mammography can be billed together.

C. Billing and Payment of Computer Aided Detection (CAD) Services.--Code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography", for CAD has been established as an add on code that can be billed in conjunction with primary service code G0202 as well as 76092. There is no Part B deductible. However, coinsurance is applicable. The add-on code cannot be billed alone. Deny the claim if only the add-on code is billed.

Code G0236, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography", for CAD has been established as an add on code that can be billed in conjunction with primary service code G0204 or G0206 as well as existing codes 76090 or 76091. The Part B deductible and co-insurance apply. The add-on code cannot be billed alone. Deny the claim if only the add-on code is billed.

NOTE: Contractors should use remark code N122, "Mammography add-on code can not be billed by itself" (Effective Sept 12, 2002), when deny a claim if only the add-on code is billed.

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. 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 Medicare Coverage Issues Manual §50-14. 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.

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	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	74185, 74185-26, 74185-TC
MRA of peripheral vessels of lower extremities	73725, 73725-26, 73725-TC