Medicare
Carriers Manual
Part 3 - Claims Process

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

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THIS TRANSMITTAL MANUALIZES CHANGE REQUEST 288.

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NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 30, 2001*
IMPLEMENTATION DATE: July 30, 2001

Section 4172.6, Billing Procedures and Modifiers for CRNA and an Anesthesiologist in a Single Anesthesia Procedure, is added to state the payment amount for each service is 50 percent of the allowance otherwise recognized had that service been furnished by the anesthesiologist alone, states the billing code to be used by each provider, and states the billing code to be used in unusual circumstances. The material is this section is new and replaces the entire section. The material previously in this section has been migrated to §4172.7 and has been revised. (See description for §4172.7 immediately following.)

Section 4172.7, Exempt CRNAs at Rural Hospitals, is revised to state certain rural hospitals can be paid on a reasonable cost basis for CRNA services. This section was previously designated as §4172.6.

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.

4172.6 Billing Procedures and Modifiers for CRNA and an Anesthesiologist in a Single Anesthesia Procedure.--Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed CRNA, and the service is furnished on or after January 1, 1998, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone.

Beginning for dates or service on or after January 1, 1998, where the CRNA and the anesthesiologist are involved in a single anesthesia case, and the physician is performing medical direction, the service is billed in accordance with the following procedures:

- For the single medically directed service, the physician will use the modifier "QY" (MEDICAL DIRECTION ONE CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) BY AN ANESTHESIOLOGIST). This modifier is effective for claims for dates of service on or after January 1, 1998, and

- For the anesthesia service furnished by the medically directed CRNA, the CRNA will use the current modifier "QX".

In unusual circumstances when it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. Documentation must be submitted by each provider to support payment of the full fee.

In unusual circumstances, the physician would report using the "AA" modifier and the CRNA would use "QZ", or the modifier for a nonmedically directed case.

4172.7 Exempt CRNAs at Rural Hospitals.--Certain rural hospitals can be paid on a reasonable cost basis for CRNA services (see §16003.G). Fiscal intermediaries will inform you of the names of CRNAs, AAs, and the hospitals which qualify for reasonable cost payments for CRNA services (see §16003.G.) During the qualifying period for reasonable cost payments, FIs will continue reimbursement under the pass-through method. Institute appropriate edits to detect duplicate billings in these situations.

4173. POSITRON EMISSION TOMOGRAPHY (PET) SCANS

BACKGROUND:

For dates of service on or after March 14, 1995, Medicare covers one use of PET scans, imaging of the perfusion of the heart using Rubidium 82 (Rb 82).

For dates of service on or after January 1, 1998, Medicare expanded coverage of PET scans for the characterization of solitary pulmonary nodules and for the initial staging of lung cancer, conditioned upon its ability to effect the management and treatment of patients with either suspected or demonstrated lung cancer. All other uses of PET scans remain not covered by Medicare.

Beginning for dates of service on or after July 1, 1999, Medicare will cover PET scans for evaluation of recurrent colorectal cancer in patients with levels of carinoembryonic antigen (CEA), staging lymphoma (both Hodgkins and non-Hodgkins) in place of a Gallium study or lymphangiogram, and for the staging of recurrent melanoma prior to surgery.

See Coverage Issues Manual §50-36 for specific coverage criteria for PET scans.

Regardless of any other terms or conditions, all uses of PET scans, in order to be covered by Medicare program, must meet the following conditions:

- Scans must be performed using PET scanners that have either been approved or cleared for marketing by the FDA as PET scanners;

- Submission of claims for payment must include any information Medicare requires to assure that the PET scans performed were: (a) reasonable and necessary; (b) did not unnecessarily duplicate other covered diagnostic tests, and (c) did not involve investigational drugs or procedures using investigational drugs, as determined by the Food and Drug Administration (FDA); and

- The PET scan entity submitting claims for payment must keep such patient records as Medicare requires on file for each patient for whom a PET scan claim is made.

4173.1 Conditions for Medicare Coverage of PET Scans for Noninvasive Imaging of the Perfusion of the Heart.--Pet scans done at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical Rubidium 82 (Rb 82) are covered for services performed on or after March 15, 1995, provided such scans meet either of the two following conditions:

- The PET scan, whether rest alone or rest with stress, is used in place of, but not in addition to, a single photon emission computed tomography (SPECT); or

o The PET scan, whether rest alone or rest with stress, is used following a SPECT that was found inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data.)

NOTE: PET scans using Rubidium 82, whether rest or stress are not covered by Medicare for routine screening of asymptomatic patients, regardless of the level of risk factors applicable to such patients.

4173.2 Conditions of Coverage of PET Scans for Characterization of Solitary Pulmonary Nodules (SPNs) and PET Scans Using FDG to Initially Stage Lung Cancer.--PET scans using the glucose analog 2-[fluorine-18]-fluoro-2-deoxy-D-glucose(FDG) are covered for services on or after January 1, 1998, subject to the condition and limitations described in CIM 50-36.

NOTE: A Tissue Sampling Procedure (TSP) should not be routinely covered in the case of a negative PET scan for characterization of SPNs, since the patient is presumed not to have a malignant lesion, based upon the PET scan results. Claims for a TSP after a negative PET must be submitted with documentation in order to determine if the TSP is reasonable and necessary in spite of a negative PET. Claims submitted for a TSP after a negative PET without documentation should be denied. Physicians should discuss with their patients the implications of this decision, both with respect to the patient's responsibility for payment for such a biopsy if desired, as well as the confidence the physician has in the results of such PET scans, prior to ordering such scans for this purpose. This physician-patient decision should occur with a clear discussion and understanding of the sensitivity and specificity trade-offs between a computerized tomography (CT) and PET scans. In cases where a TSP is performed, it is the responsibility of the physician ordering the TSP to provide sufficient documentation of the reasonableness and necessity for such procedure or procedures. Such documentation should include, but is not necessarily limited to, a description of the features of the PET scan that call into question whether it is an accurate representation of the patient's condition, the existence of other factors in the patient's condition that call into question the accuracy of the PET scan, and such other information as the contractor deems necessary to determine whether the claim for the TSP should be covered and paid.

In cases of serial evaluation of SPNs using both CT and regional PET chest scanning, such PET scans will not be covered if repeated within 90 days following a negative PET scan.

4173.3 Conditions of Coverage of PET Scans for Recurrence of Colorectal Cancer, Staging and Characterization of Lymphoma, and Recurrence of Melanoma.--Medicare adds coverage for these three new indications for PET, one for evaluation of recurrent colorectal cancer in patients with rising levels of carcinoembryonic antigen (CEA), one for staging of lymphoma (both Hodgkins and non-Hodgkins) when the PET scan substitutes for a Gallium scan, and one for the detection of recurrent melanoma, provided certain conditions are met. All three indications are covered only when using the radiopharmaceutical FDA (2-[fluorine-18]-fluoro-2-deoxy-D-glucose), and are further predicated on the legal availability of FDG for use in such scans.

4173.4 Billing Requirements for PET Scans.--

A. Effective for Services on or After January 1, 1998, Claims for Characterizing SPNs Should Include.--