CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1113	**Date: NOVEMBER 17, 2006**
	Change Request 5235

Transmittal 1014, dated July 28, 2006 is being rescinded and replaced with Transmittal 1113. The attached instruction was previously communicated as Sensitive, dated July 28, 2006. This instruction is no longer sensitive and has been updated to include the final G code that replaces the prior place holder of GXXXX. Additionally, in sections 110.1 and 110.2, "CMS" has been changed to "the Secretary of Health and Human Services", a new item has been added to section 110.2 and Advance Beneficiary Notice language has been added to the manual. All other information remains the same.

Subject: Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)

I. SUMMARY OF CHANGES: Section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysms (AAA) under Part B, effective for services furnished on or after January 1, 2007, subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test, HCPCS code G0389.

The Medicare Claims Processing Manual, Publication 100-04, Chapter 18, has been updated to include the requirements to implement §5112 of the DRA of 2005. New sections in these chapters address the payment and allowable settings for AAA.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/Table of Contents
N	18/110/Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
N	18/110.1/Definitions
N	18/110.2/Coverage
N	18/110.3/Payment
N	18/110.3.1/Deductible and Coinsurance
N	18/110.3.2/HCPCS Code
N	18/110.3.3/Advanced Beneficiary Notice

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1113	Date: November 17, 2006	Change Request 5235

Transmittal 1014, dated July 28, 2006 is being rescinded and replaced with Transmittal 1113. The attached instruction was previously communicated as Sensitive, dated July 28, 2006. This instruction is no longer sensitive and has been updated to include the final G code that replaces the prior place holder of GXXXX. Additionally, in sections 110.1 and 110.2, "CMS" has been changed to "the Secretary of Health and Human Services", a new item has been added to section 110.2 and Advance Beneficiary Notice language has been added to the manual. All other information remains the same.

SUBJECT: Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)

I. GENERAL INFORMATION

A. Background: Currently there is no Medicare coverage for ultrasound screening for abdominal aortic aneurysms. Effective January 1, 2007, the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysms (AAA), subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test, HCPCS code G0389.

NOTE: The new "G" code will be part of the annual HCPCS update for 2007 and payment will be under the Medicare Physician Fee Schedule for claims submitted to the carrier and for Skilled Nursing Facility (SNF) claims submitted to the fiscal intermediary. The description and code number for G0389 is posted in the 2007 HCPCS file. The new G0389 is also included in the 2007 Medicare Physicians Fee Schedule (MPFS).

B. Policy: Section 5112 of the DRA of 2005 allows for only one ultrasound screening test for an abdominal aortic aneurysm by Medicare, and waives the requirement of the annual Part B deductible for this screening test, furnished on or after January 1, 2007. CWF edits related to frequency, duplicate processing, and A/B Crossover will be issued in a separate Change Request at a later date.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5235.1	Effective for dates of service on and after January 1, 2007, contractors shall pay providers for one ultrasound screening for AAA, subject to certain eligibility and other limitations.	X		X						
5235.2	Contractors and Medicare system maintainers shall accept the following HCPCS code, with or without the following modifiers: **G0389** -- Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening **Short Descriptor:** Ultrasound exam AAA screen **Modifiers:** TC, 26 **TOS:** 4 (**NOTE:** The pricing will crosswalk to code 76775.)			X			X		X	
5235.3	Contractors and the Medicare System Maintainer shall accept the following HCPCS code for billing of technical services by institutional providers or professional services by Method II Critical Access Hospitals (CAHs) or Rural Health Clinics (RHCs)/Federally Qualified Health Centers (FQHCs). **G0389** -- Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening	X				X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Short Descriptor: Ultrasound exam AAA screen									
5235.4	Contractors shall pay for the AAA screening only when the services are submitted on one of the following type bills: 12X, 13X, 22X, 23X, 71X, 73X, and 85X.	X				X				
5235.5	Contractors shall pay for the technical services of G0389 on TOB 12X and 13X under the OPPS for hospitals subject to OPPS. **NOTE**: Hospitals not subject to OPPS shall be paid for the technical component under current payment methodologies.	X				X				OPPS/OCE
5235.6	Contractors shall pay for the technical services of AAA screening for Method I CAHs for TOBs 12X and 85X, at 101% of reasonable cost.	X				X				
5235.7	Contractors shall pay for the technical services of AAA screening for Method II CAHs for TOBs 12X and 85X, at 101% of reasonable cost.	X				X				
5235.8	Contractors shall pay for the professional services of AAA screening for Method II CAHs for TOB 85X, with revenue code 96X, 97X or 98X based on 115% of the MPFS. **NOTE:** This Business Requirement pertains to physician/practitioners who have reassigned their billing rights to the Method II CAH.	X				X				
5235.9	Contractors shall pay for technical services for AAA screening for Indian Health Service (IHS) providers, TOB 13X, revenue code 051X under the OMB-approved outpatient per visit all inclusive rate (AIR).	X				X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5235.10	Contractors shall pay for the technical services for AAA screening for IHS providers, TOB 12X, revenue code 024X under the all-inclusive inpatient ancillary per diem rate.	X				X				
5235.11	Contractors shall pay for technical services for AAA screening in IHS CAHs, TOB 85X, revenue code 051X at 101% of the all-inclusive facility specific per visit rate.	X				X				
5235.12	Contractors shall pay for technical services for AAA screening in IHS CAHs, TOB 12X, revenue code 024X at 101% of the all-inclusive facility specific per diem rate.	X				X				
5235.13	Contractors shall pay technical services for AAA screening for SNFs on TOBs 22X or 23X, according to the MPFS non-facility rate.	X				X				
5235.14	Contractors shall pay for the professional services for AAA screening provided in an independent or provider-based RHC or a freestanding or provider-based FQHC, TOBs 71x and 73x, respectively, 052x revenue code series, at the all-inclusive encounter rate.	X				X				
5235.15	Contractors shall pay the appropriate practitioner under MPFS for the technical services for AAA screenings provided in an independent RHC or freestanding FQHC when billed to the carrier by the practitioner.			X			X			
5235.16	Contractors shall pay the base provider for the technical services for AAA screenings provided in a provider-based RHC/FQHC, TOBs 13x and 85x using the base provider's payment methodologies.	X				X				
5235.17	Contractors shall pay for technical services for AAA screening for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland Waiver.	X				X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5235.18	Contractors shall make payment for AAA screening under the 2007 MPFS. **NOTE:** G0389 code will be part of the 2007 HCPCS file.			X			X			
5235.19	Contractors and CWF shall apply TOS 4 to G0389 when updating their payment systems. **NOTE:** The TOS will also appear in the annual 2007 TOS update.			X			X		X	
5235.20	Contractors shall waive the annual Part B deductible for ultrasound screening for AAA (G0389) effective January 1, 2007.	X		X		X	X			OPPS/OCE
5235.21	After the MPFS regulation is put on display, contractors shall instruct providers via an MLN Matters Article that the annual Part B deductible does not apply to ultrasound screening for AAA (G0389).	X		X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5235.22	After the MPFS regulation is put on display, a provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include	X		X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2007 **Implementation Date:** January 2, 2007 **Pre-Implementation Contact(s):** Bill Larson, 410-786-4639, william.larson@cms.hhs.gov, (Coverage); Roberta Epps, 410-786-4503, Roberta.epps@cms.hhs.gov, (Payment Policy); Maria Durham 410-786-6978 maria.durham@cms.hhs.gov, (FI) and Kathy Kersell, kathleen.kersell@cms.hhs.gov, 410-786-2033 (Carrier) **Post-Implementation Contact(s):** Appropriate RO	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

110 - Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
(Rev. 1113, Issued: 11-17-06, Effective: 01-01-07, Implementation: 01-02-07)

Section 5112 of the Deficit Reduction Act of 2005 amended the Social Security Act to provide coverage under Part B of the Medicare program for a one-time ultrasound screening for abdominal aortic aneurysms (AAA).

110.1 - Definitions
(Rev. 1113, Issued: 11-17-06, Effective: 01-01-07, Implementation: 01-02-07)

The term `ultrasound screening for abdominal aortic aneurysm' means--

(1) a procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, as specified by the Secretary of Health and Human Services, through the national coverage determination process) provided for the early detection of abdominal aortic aneurysms; and

(2) includes a physician's interpretation of the results of the procedure.

110.2 - Coverage
(Rev. 1113, Issued: 11-17-06, Effective: 01-01-07, Implementation: 01-02-07)

Effective for services furnished on or after January 1, 2007, payment may be made for a one-time ultrasound screening for AAA for beneficiaries who meet the following criteria:

(i) receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (as defined in section 1861(ww)(1));

(ii) receives such ultrasound screening from a provider or supplier who is authorized to provide covered diagnostic services;

(iii))has not been previously furnished such an ultrasound screening under the Medicare Program; and

(vi) is included in at least one of the following risk categories--

(I) has a family history of abdominal aortic aneurysm; or

(II) is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime

(III) is a beneficiary who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding

AAA, as specified by the Secretary of Health and Human Services, through the national coverage determination process.

110.3 - Payment

(Rev. 1113, Issued: 11-17-06, Effective: 01-01-07, Implementation: 01-02-07)

If the screening is provided in a physician office, the service is billed to the carrier using the HCPCS code identified in section 110.3.2 below. Payment is under the Medicare Physicians Fee Schedule (MPFS).

Fiscal Intermediaries (FIs) shall pay for the AAA screening only when the services are performed in a hospital, including a critical access hospital (CAH), Indian Health Service (IHS) Facility, Skilled Nursing Facility (SNF), Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC) and submitted on one of the following types of bills (TOBs): 12X, 13X, 22X, 23X, 71X, 73X, 85X.

The following describes the payment methodology for AAA Screening:

Facility	***Type of Bill***	***Payment***
Hospitals subject to OPPS	*12X, 13X*	*OPPS*
Method I and Method II Critical Access Hospitals (CAHs)	*12X and 85X*	*101% of reasonable cost*
IHS providers	*13X, revenue code 051X*	*OMB-approved outpatient per visit all inclusive rate (AIR)*
IHS providers	*12X, revenue code 024X*	*All-inclusive inpatient ancillary per diem rate*
IHS CAHs	*85X, revenue code 051X*	*101% of the all-inclusive facility specific per visit rate*
IHS CAHs	*12X, revenue code 024X*	*101% of the all-inclusive facility specific per diem rate*
*SNFs **	*22X, 23X*	*Non-facility rate on the MPFS*
*RHCs**	*71X, revenue code 052X*	*All-inclusive encounter rate*
*FQHCs**	*73X, revenue code 052X*	*All-inclusive encounter rate*
Maryland Hospitals under jurisdiction of the Health Services Cost Review	*12X, 13X*	*94% of provider submitted charges or according to the terms of the Maryland*

Commission (HSCRC) *Waiver*

** If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI using TOBs 71X and 73X, respectively, and the appropriate site of service revenue code in the 052X revenue code series.*

If the screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier under the practitioner's ID following instructions for submitting practitioner claims to the Medicare carrier.

If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI under the base provider's ID, following instructions for submitting claims to the FI from the base provider.

*** The SNF consolidated billing provision allows separate part B payment for screening services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a 22X bill type. Screening services provided by other provider types must be reimbursed by the SNF.*

110.3.1 - Deductible and Coinsurance

(Rev. 1113, Issued: 11-17-06, Effective: 01-01-07, Implementation: 01-02-07)

The Part B deductible for screening AAA is waived effective January 1, 2007. Coinsurance is applicable.

110.3.2 - HCPCS Code

(Rev. 1113, Issued: 11-17-06, Effective: 01-01-07, Implementation: 01-02-07)

Effective for services furnished on or after January 1, 2007, the following code, modifiers, and type of service (TOS) are used for AAA screening services:

> ***G0389****: Ultrasound, B-scan and or real time with image documentation; for abdominal aortic aneurysm (AAA) screening*
>
> ***Short Descriptor:*** *Ultrasound exam AAA screen*
>
> ***Modifiers:*** *TC, 26*
>
> *TOS: 4*

110.3.3 - Advance Beneficiary Notice

(Rev. 1113, Issued: 11-17-06, Effective: 01-01-07, Implementation: 01-02-07)

Medicare contractors will deny an AAA screening service billed more than once in a beneficiary's lifetime.

If a second G0389 is billed for AAA for the same beneficiary or if any of the other statutory criteria for coverage listed in section 1861(s)(2)(AA) of the Social Security Act are not met, the service would be denied as a statutory (technical) denial under section 1861(s)(2)(AA), not a medical necessity denial.

If a provider cannot determine whether or not the beneficiary has previously had an AAA screening, but all of the other statutory requirements for coverage have been met, the provider should issue the ABN-G. Likewise, if all of the statutory requirements for coverage have been met, but a question of medical necessity still exists, the provider should issue the ABN-G.