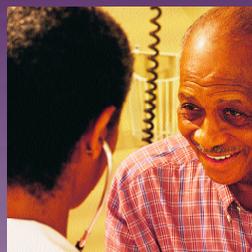
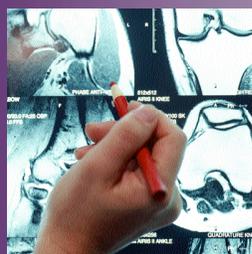




Medicare Preventive Services:

Osteoporosis, Diabetes and Prostate Cancer



**A Guide to Billing
Bone Density Studies,
Diabetes Self-
Management Training
Services, and Prostate
Screening Services**



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<http://www.ama-assn.org/ama/pub/category/3884.html>

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*On October 1, 2003 CMS transitioned from a paper based manual system to a Web-based system. The new system is called the **CMS Online Manual System** (also called the Medicare and Medicaid Program Instructions website) and is located at:*

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Please use this site to find information regarding eligibility, entitlement, claims processing, benefit policy and program integrity.

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INTRODUCTION



A Guide to Billing Bone Density Studies, Diabetes Self-Management Training Services, and Prostate Screening Services

Every year the statistics improve. Some diseases, such as certain types of cancer, including prostate cancer, are now being discovered in the early stages, where they can be successfully treated and possibly even cured.

Patient education plays a major role in the good news. Research has shown that very often the most important way to promote early detection is through the physician or other health care professional. Physicians can stress the need for prevention and early detection that can improve a person's quality of life. For example, patients with diabetes can learn to control their lives by controlling their disease. In other diseases, such as osteoporosis, tests can alert patients to their risk of disease, enabling them to make lifestyle choices that may reduce or alter that risk.

This national focus on prevention and early detection has resulted in a higher level of consumer interest in preventive medicine, including Medicare preventive benefits.

The Centers for Medicare & Medicaid Services' (CMS) comprehensive training program promotes awareness and increased use of these proactive Medicare benefits. The program assists health care providers to build their practices by promoting wellness and explains billing requirements.

This resource booklet discusses Medicare coverage and billing guidelines for several preventive services, including bone density studies, prostate screening antigen (PSA) blood test, and digital rectal examination (DRE); it also describes diabetes self-management training (DSMT) services, and billing requirements, to assist in effective claims filing.

OSTEOPOROSIS



Bone Density Studies

What are Bone Density Studies?

The term “bone mass measurement” is synonymous with “bone density study.” It is defined as a radiological or radioisotope procedure or other procedure approved by the Food and Drug Administration (FDA) performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss or determining bone quality. Bone density studies are used to evaluate diseases of the bone and/or the responses of bone disease treatment; they include a physician’s interpretation. The studies assess bone mass or density associated with such diseases as osteoporosis and other bone abnormalities. Various single and combined methods of measurement may be required to diagnose bone disease, monitor the course of bone changes with disease progression, or monitor the course of bone changes with therapy. Bone density is usually studied by using photodensitometry, single or dual photon absorptiometry or bone biopsy.

Bone density can be measured at the wrist, spine, hip, or calcaneus. The medical literature is divided on the accuracy of predicting osteoporosis of the spine or hip by measuring peripheral sites (wrist, calcaneus). It does appear, however, that bone density measurement of the involved bone gives a better measurement of osteoporosis than does measurement of another bone not known to be involved.

Standardizing Bone Density Studies

One concern with bone density studies is a lack of standardization that results in inconsistent test results. Tests should be done on the same suitably precise instrument, to ensure accuracy; but, because systematic differences among scanners have been found, it is also important to use results obtained with the same type of scanner, when comparing a patient to a control population. To ensure reliability of bone density studies, the densitometry technologist must have proper training in performing this procedure. Malpositioning of the patient or incorrect analysis of a scan can lead to major errors in bone density studies. In addition, precise calibration of the equipment is required for accuracy and to reduce variation of test results and risk of misclassification of the degree of bone density.

Bone Density Studies Coverage Guidelines

The Balanced Budget Act of 1997 (BBA) provided for standardization of Medicare coverage of bone density studies. This standardized coverage is effective for claims with dates of service on or after July 1, 1998.

Bone density studies are covered for patients with any one of the following indications:

- A patient with vertebral abnormalities, as demonstrated by an X-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture.
- A patient being monitored to assess the response to or efficacy of an FDA approved osteoporosis drug therapy.
- A patient with known primary hyperparathyroidism.
- A patient receiving (or expecting to receive) corticosteroid therapy (greater than three months or the equivalent dose of 30 mg cortisone [or 7.5 mg prednisone] or greater per day).
- A woman who is estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.

In addition, all coverage criteria listed below must be met:

- The individual's physician or qualified non-physician practitioner treating the patient must provide an order, following an evaluation of the need for a measurement that includes a determination as to the medically appropriate measurement to be used for the individual.
- The service must be furnished by a qualified supplier or provider of such services under at least the general level of physician supervision.
- The service must be reasonable and necessary for diagnosing, treating, or monitoring an individual as defined above.
- The service must be performed with a bone densitometer or a bone sonometer device approved or cleared for marketing by the FDA for bone density study purposes, with the exception of dual photon absorptiometry devices.



Statutory Required Frequency Parameters

Medicare may cover a bone density study for a patient once every two years (if at least 23 months have passed since the month the last bone density study was performed). However, if medically necessary, Medicare may cover a bone density study for a patient more frequently than every two years. Examples of situations where more frequent bone density study procedures may be medically necessary include, but are not limited to, the following medical conditions:

- Monitoring patients on long-term glucocorticoid (steroid) therapy of more than three months.
- Allowing for a confirmatory baseline bone density study (either central or peripheral) to permit future monitoring of a patient, if the initial test was performed with a different technique than the proposed monitoring method. For example, if the initial test was performed using bone sonometry, and monitoring is anticipated using bone densitometry, Medicare will allow coverage of baseline measurement using bone densitometry.

Types of Densitometers

Medicare provides coverage for the following types of densitometers:

- **Stationary:** a device that is permanently located in an office.
- **Mobile:** a device that is transported by vehicle from site to site.
- **Portable:** a device that can be picked up and moved from one site to another.

Procedure Codes and Descriptors

Bone density studies are performed to establish the diagnosis of osteoporosis and to assess the individual's risk for subsequent fracture. Bone densitometry includes the use of single photon absorptiometry (SPA), single energy X-ray absorptiometry (SEXA), dual photon absorptiometry (DEXA), quantitative computed tomography (QCT), and bone ultrasound densitometry (BUD).

The following HCPCS/CPT codes have been established for reporting of peripheral and central DEXA studies:

- **G0130 Single energy X-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).**
- **76070 Computed tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine).**

- **76071 Computed tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).**
- **76075 Dual energy X-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine).**
- **76076 Dual energy X-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).**
- **76078 Radiographic absorptiometry (photodensitometry), one or more sites.**
- **76977 Ultrasound bone density measurement and interpretation, peripheral site(s), any method.**
- **78350 Bone density (bone mineral content) study, one or more sites; single.**
- **0028T Dual energy X-ray absorptiometry (DEXA), body composition study, one or more sites.**

Diagnosis Requirements

Contact the Medicare carrier or intermediary in your state for specific diagnosis codes that are payable for bone density studies.

Coding Tips

When billing Medicare for bone density studies, a bone density study procedure code should be billed only once, regardless of the number of sites being tested or included in the study (e.g., if the spine and hip are performed as part of the same study, only one can be billed).

Documentation Requirements

Medical record documentation maintained by the treating physician must clearly indicate the medical necessity for ordering bone density studies. The documentation may be included in any of the following:

- History and physical
- Office notes
- Test results with written interpretation
- X-ray/radiology with written interpretation



Payment Requirements for Carriers

Reimbursement of bone density studies is made on the basis of the Medicare physician fee schedule. Deductible and co-insurance are applicable. Claims from physicians, non-physician practitioners, or suppliers where assignment was not taken are subject to Medicare’s limiting charge.

Payment Requirements for Intermediaries

When billing using the CMS-1450 or electronic equivalent, the following billing requirements should be considered:

- **Applicable Bill Types.** The appropriate bill types are 12X, 13X, 14X, 22X, 23X, 34X, 71X (Provider-based and independent), 72X, 73X (Provider-based and freestanding), 83X and 85X. Providers utilizing the UB-92 flat file use record type 40 to report bill type. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), and type of bill (Field No. 4) are required. Providers utilizing the hard copy UB-92 (CMS-1450) report the applicable bill type in Form Locator (FL) 4 “Type of Bill.”
- **Coding Requirements.** Providers must report HCPCS/CPT codes for bone density studies under revenue code 320. In addition, they must report the number of units, and line item dates of service per revenue code line for each mass measurement reported. Line item date of service reporting is effective for claims with dates of service on or after October 1, 1998. Providers utilizing the UB-92 flat file use record type 61 to report the bone mass procedure. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), revenue code 320 (Field No. 4), HCPCS code, as appropriate (Field No. 5), units of service (Field No. 8), date of service (Field No. 12) and outpatient total charges (Field No. 10) are required. Providers utilizing the hard copy UB-92 (CMS-1450) report the appropriate HCPCS/CPT code in FL 44 “HCPCS/Rates,” and revenue code 320 in FL 42 “Revenue Code.” The date of service is reported in FL 45 “Service Date” (MMDDYYYY), and the number of service units in FL 46 “Service Units.”

Bone density studies will be reimbursed under current payment methodologies for radiology services. Part B deductible and co-insurance are applicable.

Reasons for Denial

Medicare may deny bone density studies:

- When performed for indications other than those listed under the “Coverage Guidelines” section listed previously in this document.



- When the appropriate physician or qualified non-physician practitioner does not order tests. For purposes of this provision, a physician or qualified non-physician practitioner is one who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the patient.
- Bone density studies of any type, including DEXA scans, are not covered under the portable X-ray benefit. The benefit allows X-ray films of the skeleton, chest, or abdomen. Although bone density studies are radiology procedures, they are not X-ray films. In addition, the portable X-ray service benefit requires that equipment be portable enough to provide services at home.
- When submitted with diagnosis codes that are not payable for the procedure (if applicable).

Note: CPT 78351 (Dual Photon Absorptiometry) is non-covered by Medicare Coverage Issues Manual 50-44. (This procedure should not be reported under CPT codes 76075 or 76076).

Unique Physician Identification Number (UPIN) Requirements

Any service that is ordered or referred by a physician requires the ordering/referring physician's name and UPIN in Fields 17 and 17a on Form CMS-1500. If submitting electronically, the UPIN of the ordering/referring physician goes in record FB1, field 13, and the name goes in record FB1, fields 10, 11, and 12.



DIABETES



Diabetes Self-Management Training Services (DSMT)

What are DSMT Services?

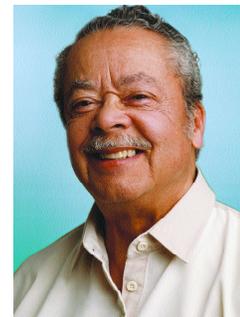
Section 4105 of the Balanced Budget Act of 1997 (BBA) permits Medicare coverage of DSMT services, effective July 1, 1998, when these services are furnished through a certified program that meets certain quality standards. These requirements were updated in a final regulation effective February 17, 2001; refer to CFR 410.141 in **IOM, PUB 100-2, Chapter 15, Section 300 (Diabetes Self Management Training Services)**, at website:

www.cms.hhs.gov/manuals

A diabetes self-management and training program should educate beneficiaries in the successful self-management of diabetes. The training program should offer training and be capable of meeting the needs of its patients on the following subjects:

- Diabetes overview/pathophysiology of diabetes
- Nutrition
- Exercise and activity
- Diabetes medications (including skills related to the self-administration of injectable drugs)
- Self-monitoring and use of the results
- Prevention, detection, and treatment of chronic complications
- Prevention, detection, and treatment of acute complications
- Foot, skin, and dental care
- Behavior changes strategies, goal setting, risk factor reduction, and problem solving
- Preconception care, pregnancy, and gestational diabetes
- Relationships among nutrition, exercise, medication, and blood glucose levels

- Stress and psychological adjustment
- Family involvement and social support
- Benefits, risks, and management options for improving glucose control
- Use of health care systems and community resources



DSMT services may be covered under Medicare only if the physician managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care. This plan of care must describe the content, number of sessions, frequency, and duration of the training written by the physician (or qualified non-physician practitioner) treating the beneficiary. There must be a statement by the physician (or non-physician practitioner) managing the beneficiary's diabetic condition; any changes to the plan of care must be signed by the physician (or qualified non-physician practitioner) managing the beneficiary's diabetic condition; and the plan of care must be reasonable and necessary and incorporated into the approved entity's medical record.

Eligible Education Programs

To be reimbursed by Medicare for DSMT services, programs must:

- Be accredited as a diabetes self-management training program by the American Diabetes Association or the Indian Health Service.
- Provide services to eligible Medicare beneficiaries that are diagnosed with diabetes.

An accreditation certificate from the American Diabetes Association (ADA), Indian Health Service (IHS) or other Centers for Medicare & Medicaid Services (CMS) recognized program must be submitted to the local Medicare contractor's provider enrollment department.

Billing and Coding Requirements for All Claims

Before billing for DSMT services, all providers must submit to the Medicare contractor an accreditation certificate from the American Diabetes Association (ADA), Indian Health Service (IHS) or other CMS recognized program. The certification should be sent to the local contractor's provider enrollment department.

To avoid delays in payment for services, a cover letter and Provider Identification Number (PIN) must be included with the certificate. You must have a provider/supplier number and the ability to bill Medicare for other services. All Medicare providers and suppliers are eligible to bill for DSMT services if they are associated with an accredited DMST program. Billings for DSMT services cannot be done as incident to services. However, a physician advisor for a DSMT program

is eligible to bill for the DSMT services for that program. If you are a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier, you must obtain an additional PIN from your local carrier.

Billing and Coding Requirements Specific to Billing an Intermediary

When billing using Form CMS-1450 or the electronic equivalent, the following billing requirements should be remembered:

- **Applicable Bill Types.** The appropriate bill types are 12X, 13X, 34X (can be billed if service is outside of the treatment plan), 72X, 74X, 75X, 83X and 85X.
- **Coding Requirements.** Providers must report HCPCS codes for DSMT services under revenue code 942.

When billing for these services, a copy of the provider’s certification must be submitted with his/her initial claim.

Procedure Codes and Descriptors

The following HCPCS codes have been established for diabetes self-management services:

- **G0108 Diabetes outpatient self-management training services, individual, per 30 minutes.**
- **G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes**

Services for DSMT must be billed with the appropriate HCPCS code G0108 or G0109, in **half-hour** increments only.

Note: Providers billing Intermediaries must place revenue code 942 on the claim with the appropriate HCPCS code.

Coding Tips

- For an hour session a “2” must be placed in the units column, representing “2” 30 minute increments.
- Billing an evaluation and management code is not mandatory before billing the diabetes self-management training procedure codes. Also, do not use evaluation and management codes in lieu of G0108 and G0109.
- The nutrition portion of the DSMT program must be billed using G0108 and G0109. Do not use the Medical Nutrition Therapy CPT codes for the nutrition portion of a DSMT program.

- The DSMT and medical nutrition therapy benefits can be provided to the same beneficiary in the same year. However, they are different benefits and require separate referrals from physicians or qualified non-physician practitioners. The medical evidence reviewed by CMS suggests that the medical nutrition therapy benefit for diabetic patients is more effective if provided after completion of the initial DSMT benefit.
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are permitted to become accredited providers of DSMT and medical nutrition therapy services and bundle the cost of such services into their clinic/center payment rates. However, FQHCs and RHCs must meet all coverage requirements.
- Medicare covers 10 hours of initial DSMT in a continuous 12-month period. Two hours of follow-up DSMT may be covered in subsequent years.

Payment Requirements for Carriers and Intermediaries

Reimbursement of DSMT services is made on the basis of the Medicare physician fee schedule. In addition, deductible and co-insurance are applicable when this service is provided.

Unique Physician Identification Number (UPIN)

Any service that is ordered or referred by a physician requires the ordering/referring physician's name and UPIN in Blocks 17 and 17a on Form CMS-1500. If submitting electronically, the UPIN of the ordering/referring physician goes in record FB1, Field 13, and the name goes in record FB1, Fields 10, 11, and 12.



Written Advance Notice Requirements

Providers are responsible for giving beneficiaries written Advance Beneficiary Notices when coverage requirements are not met.

Other Medicare Covered Services for Diabetic Patients

In addition to the DSMT services, Medicare covers medical equipment that can be utilized by patients to monitor blood sugar level and to maintain a constant insulin level.

Prior to the implementation of Section 4105 of the BBA, Medicare covered blood glucose monitors and its associated accessories and supplies only when the patient was diagnosed as an insulin-dependent diabetic. Effective July 1, 1998, Medicare coverage was extended to non-insulin dependent diabetics.

Prior to April 1, 2000, Medicare payment was not made for an external insulin infusion pump. However, as of April 1, 2000, the existing non-coverage policy on this item is being revised to *limited* coverage, based on established medical necessity requirements.

For further information regarding Medicare's medical necessity requirements and claim filing information for the above-mentioned items, please contact your local Durable Medical Equipment Regional Carrier (DMERC). For the name, address, and telephone number of the DMERC in your area, please access the following website: <http://cms.hhs.gov/suppliers/dmepos/default.asp>.

Medicare also covers Medical Nutrition Therapy for beneficiaries diagnosed with diabetes. The benefit requires a physician referral. The benefit must be provided by a qualified dietitian, licensed registered dietitian, a licensed nutritionist that meets registered dietitian requirement, or a grand fathered nutritionist that was licensed as of December 12, 2000. For more information, contact the above website.

PROSTATE CANCER



Covered Medicare Screening Procedures

What is a Prostate Specific Antigen (PSA) Test?

PSA, a tumor marker for adenocarcinoma of the prostate, can predict residual tumor in the post-operative phase of prostate cancer. Three to six months after a radical prostatectomy, PSA is reported as providing a sensitive indicator of persistent disease. Six months following introduction of antiandrogen therapy, PSA is reported as capable of distinguishing patients with favorable response from those in whom limited response is anticipated.

PSA is not in itself a diagnostic test; however, once a diagnosis has been established, it serves as a marker to follow the progress of most prostate tumors. PSA also aids in managing prostate cancer patients and in detecting metastatic or persistent disease in patients following treatment.

PSA is of proven value in differentiating benign from malignant disease in men with lower urinary tract signs and symptoms (e.g., hematuria, slow urine stream, hesitancy, urgency, frequency, nocturia, and incontinence). It is also of value in men with palpably abnormal prostate glands on physical exam, and men with

other laboratory or imaging studies that suggest the possibility of a malignant prostate disorder. PSA testing may also be useful in the differential diagnosis of men presenting with as yet undiagnosed disseminated metastatic disease.



The PSA blood test is not perfect; however, it is the best test currently available for early detection of prostate cancer. Since doctors started using this test, the number of prostate cancers found at an early, curable stage has increased. Since most men have normal test results, this is reassurance that they are unlikely to have prostate cancer, especially if their digital rectal exam (DRE) result is also negative.

What is a Screening Digital Rectal Examination (DRE)?

A screening digital rectal examination is a clinical exam of an individual's prostate for nodules or other abnormalities.

Prostate Cancer Screening Coverage Guidelines

Section 4103 of the Balanced Budget Act of 1997 (BBA) provides for coverage of certain prostate cancer screening tests, subject to coverage, frequency, and payment limitations. Effective for services furnished on or after **January 1, 2000**, Medicare will cover prostate cancer screening tests/procedures for the early detection of prostate cancer. Medicare covers both screening digital rectal examinations and screening prostate specific antigen tests.

- **Screening Digital Rectal Examinations (DRE)** are covered at a frequency of once every 12 months for men who have attained age 50 (Coverage begins the day after reaching age 50). This screening must be *performed* by a doctor of medicine or osteopathy or by a physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife. The screening provider must be authorized under state law to perform the examination, be fully knowledgeable about the beneficiary's medical condition, and be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.
- **Screening Prostate Specific Antigen (PSA) Blood Tests** are covered at a frequency of once every 12 months for men who have attained age 50. This screening must be *ordered* by the beneficiary's physician or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife. The screening provider must be authorized under state law to perform the examination, be fully knowledgeable about the beneficiary's medical condition, and be responsible for using the results of any examination (test) performed in the overall management of the beneficiary's specific medical problem.

Statutory Required Frequency Parameters

For Medicare male beneficiaries over age 50, “annual” frequency is determined in this manner: Once a beneficiary has received any/all of the covered prostate cancer screening tests/procedures, he may receive another (or all) of such tests/procedures after 11 full months have elapsed since the last covered screening. Counting begins with the month after the last exam. For example, if the last covered test were performed on February 25, 2003, counting would begin with the month of March 2003. The beneficiary would then be eligible for the next test on or after February 25, 2004 (the month after 11 full months have passed).

Procedure Codes and Descriptors

Medicare allows payment for the following procedure codes:

- **G0102 Prostate cancer screening; digital rectal examination.**
- **G0103 Prostate cancer screening; prostate specific antigen test (PSA), total.**

Diagnosis Requirements

There are no specific diagnosis requirements for prostate screening tests/procedures; however, if screening is the reason for the test/procedure, the appropriate screening (“V”) diagnosis code must be chosen when billing Medicare.

Reasons for Denial

Following are some reasons that Medicare may deny prostate screening tests and procedures:

- Beneficiary does not meet specified statutory age for the test/procedure.
- Beneficiary has exceeded statutory required frequency parameters for the test/procedure.
- Beneficiary received a covered Evaluation and Management (E/M) service on the same day in which the DRE was performed (only the DRE will be denied; PSA will be covered). In this situation the E/M service would be covered and the DRE would be denied.

Payment Requirements for Carriers

The DRE screening exam is reimbursed based on the physician’s fee schedule. Additionally, the deductible and co-insurance **are** applicable when this service is provided. The PSA screening test is reimbursed under the clinical laboratory fee schedule. The deductible and co-insurance are **not** applicable when this service is provided.

Payment Requirements for Intermediaries

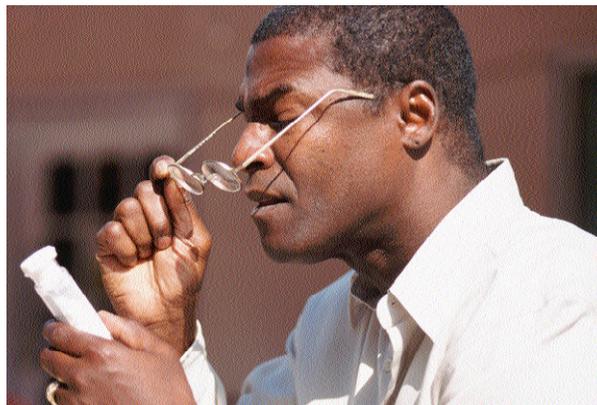
When billing using Form CMS-1450 or the electronic equivalent, the following billing requirements should be considered:

- **Applicable Bill Types.** The appropriate bill types are 12X, 13X, 14X, 22X, 23X, 42X, 52X, 71X, 73X, 83X, and 85X.
- **Coding Requirements.** Providers must report HCPCS codes for prostate screening under revenue code 30X for the DRE and 770 for the PSA.

The DRE screening exam is reimbursed based on a reasonable cost basis. Additionally, the deductible and co-insurance **are** applicable when this service is provided. The PSA screening test is reimbursed under the clinical diagnostic laboratory fee schedule. The deductible and co-insurance are **not** applicable when this service is provided.

UPIN Requirements

Any service that is ordered or referred by a physician requires the ordering/referring physician's name and UPIN in Blocks 17 and 17a on Form CMS-1500. If submitting electronically, the UPIN of the ordering/referring physician goes in record FB1, field 13, and the name goes in record FB1, Fields 10, 11, and 12.



RESOURCES



The following resources are available to physicians by mail order, telephone, and the Internet.

Publications

The Current Procedural Terminology (CPT) book is a listing of descriptive terms and identifying codes for recording medical services and procedures performed by physicians and is effective for the current year.

Level I — CPT Book

American Medical Association
1-800-621-8335
www.amapress.org

The Healthcare Common Procedure Coding System (HCPCS) book contains national codes for recording medical services and procedures performed by physicians and is effective for the current year.

Level II — HCPCS Book

American Medical Association
1-800-621-8335
www.amapress.org

The International Classification of Diseases, 9th Revision, Clinical Management (ICD-9-CM) book contains diagnosis codes effective for the current year.

ICD-9-CM Diagnosis Coding Book

American Medical Association
1-800-621-8335
www.amapress.org

Note: Medicare carriers annually update CPT and HCPCS codes within the Medicare processing system. These changes are effective each year on January 1, and have a 90-day grace period (through March 30). ICD-9-CM codes are also updated annually and become effective October 1 each year.

Medicare Part A and B Publications

All contractors are required to publish Medicare changes, local policy, and fee schedule updates on a regular basis. All of these publications may be obtained by contacting your local Medicare Carrier.

Local Medicare Carrier toll-free customer service phone numbers offer service representatives that can provide clear answers to billing questions. A complete listing may be found at:

www.cms.gov/medlearn/tollnums.asp

Web Sites

Free Medicare Education

CMS offers Medicare education for all Medicare physicians and staff. Free, downloadable, Web-based courses as well as other free educational items are available at:

www.cms.gov/medlearn

Provider Enrollment

Enrollment information for suppliers and providers of Medicare services including forms and instructions on how to complete the forms may be available at:

www.cms.hhs.gov/providers/enrollment

Quality of Care

CMS is committed to improving the health and satisfaction of all beneficiaries through an integrated quality improvement program. Information on many quality improvement initiatives is available at:

www.cms.gov/quality

Internet Only Manual

On October 1, 2003 CMS transitioned from a paper based manual system to a Web-based system. The new system is called the CMS Online Manual System (also called the Medicare and Medicaid Program Instructions website) and is located at:

<http://www.cms.hhs.gov/manuals>

Please use this site to find information regarding eligibility, entitlement, claims processing, benefit policy and program integrity.

This information is available at the Medicare website:

www.medicare.gov

DME Claims

Claims for supplies, orthotics, prosthetics, equipment, and certain injectables are submitted to the Durable Medical Equipment Regional Carrier (DMERC). A list of DMERCs can be found at the following website:

www.cms.hhs.gov/contacts/incardir.asp

Form CMS-1500

Form CMS-1500 (for physician and supplier services) and other forms are available in various formats from the U.S. Government Printing Office (GPO). The GPO may be contacted for purchase information at:

Web site: **<http://bookstore.gpo.gov>**

Telephone: 1-866-512-1800

Mailing address: Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

Sanctioned Provider Lists

The Government Services Administration (GSA) debarment, exclusion, and suspension lists for all federal agencies are available on the Internet at:

<http://epls.arnet.gov>

This website will assist Medicare and Medicaid contractors to verify the eligibility of healthcare providers and/or entities seeking to participate in the Medicare and Medicaid Programs.

The DHHS/OIG sanctioned provider list is on the Internet at:

<http://exclusions.oig.hhs.gov>

The documents issued by the OIG on compliance program guidance are published in the Federal Register and are on the Internet at:

<http://oig.hhs.gov/modcomp/index.htm>

