CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 795

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 30, 2005

Change Request 4208

SUBJECT: Redefined Type of Bill (TOB) 14X for Non-Patient Laboratory Specimens-CR 3835 Manualization

I. SUMMARY OF CHANGES: This instruction provides manual changes to conform with Change Request 3835 in various claims processing manual chapters.

NEW/REVISED MATERIAL
EFFECTIVE DATE: *October 01, 2004
IMPLEMENTATION DATE: April 03, 2006

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 – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	2/90.4/Type of Bill
R	4/10.4/Packaging
R	4/120/General Rules for Reporting Outpatient Hospital Services
R	4/120.1/Bill Types Subject to OPPS
R	4/250.1/Standard Method - Cost-Based Facility Services, With Billing of Carrier for Professional Services
R	4/250.1.2/Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services
R	4/250.1.3/CRNA Services (CRNA Pass-Through Exemption of 115 Percent Fee Schedule Payments for CRNA Services
R	4/250.2/Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services
R	13/20.2.1/Hospital and Skilled Nursing Facility (SNF) Patients

R	13/40.1.3/Special Billing Instructions for RHCs and FQHCs
R	13/40.1.4/Payment Requirements
R	13/140.3/Payment Methodology and HCPCS Coding
R	16/10.2/General Explanation of Payment
R	16/30.3/Method of Payment for Clinical Laboratory Tests - Place of Service Variation
R	16/40.3/Hospital Billing Under Part B
R	16/40.3.1/Critical Access Hospital (CAH) Outpatient Laboratory Service
R	18/20.2.1/Computer-Aided Detection (CAD) Add-On Codes
R	18/30.4.1/Payment Method for RHCs and FQHCs
R	18/30.5/HCPCS Codes for Billing
R	18/30.7/Type of Bill and Revenue Codes for Form CMS-1450
R	18/40.6/Revenue Code and HCPCS Codes for Billing
R	18/50.3/Payment Method - FIs and Carriers
R	18/50.4/HCPCS, Revenue, and Type of Service Codes
R	32/10.1/Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements
R	32/12.3/FI Billing Requirements
R	32/40.3/Bill Types

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 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: 795	Date: December 30, 2005	Change Request: 4208

SUBJECT: Redefined Type of Bill (TOB) 14X, for Non-Patient Laboratory Specimens-CR 3835 Manualization

I. GENERAL INFORMATION

A. Background: Transmittal 734**,** Change Request 3835 titled "Redefined Type of Bill (TOB), 14X, for Non-Patient Laboratory Specimens" implements April 3, 2006 the redefined type of bill (TOB) 14X to be used for non-patient laboratory specimens**.** A non-patient is defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital that has a specimen that is submitted for analysis and the beneficiary is not physically present. This instruction provides manual changes to conform with Change Request 3835 in various claims processing manual chapters.

B. Policy: The National Uniform Billing Committee (NUBC) has redefined the TOB 14X to be limited in use for non-patient laboratory specimens.

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	
4208.1	Contractors and maintainers shall be in compliance with the instructions in Pub. 100-04, Medicare Claims Processing Manual, Chapter 2, Section 90.4, Chapter 4, Sections 10.4, 120, 120.1, 250.1, 250.1.2, 250.1.3, 250.2, Chapter 13, Sections 20.2.1, 40.1.3, 40.1.4, 140.3, Chapter 16, Sections 10.2, 30.3, 40.3, 40.3.1, Chapter 18, Sections 20.2.1, 30.4.1, 30.5, 30.7, 40.6, 50.3, 50.4, Chapter 32, Sections 10.1, 12.3, and 40.3.	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	
None										

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
4208.1	CR 3835 Redefined TOB, 14X, for Non-Patient Laboratory Specimens

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*: April 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Valeri Ritter, valeri.ritter@cms.hhs.gov, 410-786-8652; Taneka Rivera, taneka.rivera@cms.hhs.gov, 410-786-9502	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

Post-Implementation Contact(s): Appropriate RO	

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

90.4 - Type of Bill

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

To properly bill, the provider assigns type of bill *(TOB) 13X to all bills for outpatient diagnostic testing services and TOB 14X for non-patient laboratory specimens. A non-patient is defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present.*

TOB 14X should only be billed for non-patient lab specimens. Laboratory tests payable on the laboratory fee schedule for a non-patent laboratory specimen TOB 14X are the lesser of the actual charge, the fee schedule amount, or the National Limitation Amount (NLA),(including CAHs and MD Waiver hospitals). Part B deductible and coinsurance do not apply for laboratory tests payable on the laboratory fee schedule. Laboratory tests not payable on the laboratory fee schedule will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS.

TOB 14X should no longer be used for other referred diagnostic services. CAHs should continue to bill TOB 85X for outpatient lab services. Lab services should be billed on TOB 13X for all other hospital outpatients.

10.4 - Packaging

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Initial packaging rules for OPPS implementation are:

- Initially, only minimal packaging, i.e., payment for a procedure or medical visits does not include payment for the related ancillary services such as laboratory tests or x-rays;
- Payment for clinical diagnostic laboratory tests which are paid under the clinical diagnostic fee schedule and radiology and other diagnostic services paid under OPPS will be made in addition to the OPPS payment for a surgical procedure or medical visit performed on the same day; and
- APC payments will include certain packaged items, such as anesthesia, supplies, certain drugs and the use of recovery and observation rooms.

Under OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.

A. Claims Resulting in APC Payments

If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) as well as for future rate setting.

Claims Resulting in No APC Payments

If the claim contains only services payable under cost reimbursement, such as corneal tissue, and services that would be packaged services if an APC were payable, then the packaged services are not separately payable. In addition, these charges for the packaged services are not used to calculate TOPs.

If the claim contains only services payable under a fee schedule, such as clinical diagnostic laboratory, and also contains services that would be packaged services if an APC were payable, the packaged services are not separately payable. In addition, the charges are not used to calculate TOPs.

If a claim contains services payable under cost reimbursement, services payable under a fee schedule, and services that would be package services if an APC were payable, the packaged services are not separately payable. In addition, the charges are not used to calculate TOPs payments.

During claims processing of bill types 12X *and* 13X cost reimbursement payments may not be made to hospital outpatient departments for any items or services except for corneal tissue and certain CRNA services, orphan drugs, and ESRD drugs and supplies

not included in the composite rate. *Effective 4/1/06, 14X type of bill is for non-patient laboratory specimens and is no longer applicable for cost reimbursement payment.*

120 - General Rules for Reporting Outpatient Hospital Services

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Hospitals use *the ANSI X12N 837 I or the hardcopy* Form *CMS-1450 UB-92 to bill* for covered outpatient services (type of bill 13X or 83X, and 85X). See:

- Medicare Benefit Policy Manual, Chapter 6, for definition of an outpatient;
- Medicare Claims Processing Manual, Chapter 3, "Inpatient Part A Hospital Billing," for outpatient services treated as inpatient services; and
- Medicare Claims Processing Manual, Chapter 25, for general instructions for completing the *ANSI X12N 837 I or the hardcopy* Form *CMS-1450* UB-92.

The HCPCS code is used to describe services where payment is under the Hospital OPPS or where payment is under a fee schedule or other outpatient payment methodology. Line item dates of service are reported for every line where a HCPCS code is required under OPPS. For providers paid via OPPS, FIs return to provider (RTP) bills where a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the statement-covers period. This includes those claims where the "from and through" dates are equal.

120.1 - Bill Types Subject to OPPS

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The following bill types are subject to OPPS:

- All outpatient hospital Part B bills (bill types 12X, 13X with condition code 41 14X *and* 13X without condition code 41) with the exception of bills from hospitals in Maryland, Indian Health Service, CAHs, hospitals located in Saipan, American Samoa, the Virgin Islands and Guam; and hospitals that provide Part B only services to their inpatients. *Effective 4/1/06 the 14X type of bill is for non-patient laboratory specimens and is no longer applicable for partial hospitalization billing.*
- CMHC bills (bill type 76X);
- CORF claims for hepatitis B vaccines (bill type 75X);
- HHA claims for antigens, hepatitis B vaccines, splints and casts (bill type 34X); and
- For splints, casts and antigens when provided to hospice patients for treatment of a non-terminal illness by other than a hospital outpatient department. This requires reporting of condition code 07.

As a result, FIs shall instruct CORFs, HHAs, and other providers to report HCPCS for these services, in order to assure payment under this system. Payment will continue to be made for vaccines provide to hospice patients by the Medicare Part B carrier. The appropriate HCPCS codes are as follows:

Antigens	95144-95149, 95165, 95170, 95180, and 95199
Vaccines	90657-90659, 90732, 90744, 90746, 90747, 90748, G0008, G0009, and G0010
Splints	29105-29131, 29505-29515
Casts	29000-29085, 29305, 29325-29445, 29450, 29700-29750, 29799

NOTE: FIs shall advise their HHAs to report the above HCPCS codes with the exception of vaccines under Revenue Code 0550 (Skilled Nursing). The only time revenue code 0550 may be reported is when the HHA is billing for antigens, splints, or casts. See Chapter 18 for the reporting of vaccines by HCPCS codes.

250.1 - Standard Method - Cost-Based Facility Services, With Billing of Carrier for Professional Services

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient CAH services under this method will be made for the lesser of 1) 80 percent of 101 percent of the reasonable cost of the CAH in furnishing those services, or 2) 101 percent of the reasonable cost of the CAH in furnishing those services, less applicable Part B deductible and coinsurance amounts.

Payment for professional medical services furnished in a CAH to CAH outpatients is made by the carrier on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a physician assistant that could be billed directly to a carrier under Part B of Medicare or a nurse practitioner that could be billed directly to a carrier under Part B of Medicare.

In general, payment for professional medical services, under the cost-based CAH payment plus professional services billed to the carrier method should be made on the same basis as would apply if the services had been furnished in the outpatient department of a hospital.

Bill type 85X is used for all outpatient services including services approved as ASC services. *Non-patient laboratory specimens* (those not meeting the criteria for reasonable cost payment in §250.6) will be billed on a 14X type of bill.

(See Section 260.6 – Clinical Diagnostic Laboratory Tests Furnished by CAHs).

Low Osmolar Contrast Material (LOCM) furnished as part of medically necessary imaging procedures for CAH outpatients is paid based on bill type 85X. Bills must include revenue code 636 along with one of the following HCPCS codes as appropriate:

A4644 Supply of low osmolar contrast material (100 – 199 mgs of iodine);

A4645 Supply of low osmolar contrast material (200 – 299 mgs of iodine); or

A4646 Supply of low osmolar contrast material (300 – 399 mgs of iodine).

250.1.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period. Under this election a CAH will receive payment for all professional services received in that CAH's outpatient department (all licensed professionals who otherwise would be entitled to bill the carrier under Part B).

Payment to the CAH for each outpatient visit will be the sum of the following:

- For facility services, not including physician or other practitioner, payment will be the reasonable costs of the services. On the *ANSI X12N 837 I or the hardcopy* Form *CMS-1450 (UB-92),* list the facility service(s) rendered to outpatients along with the appropriate revenue code. Pay the amount equal to the sum of 80 percent of its reasonable costs of its outpatient services after application of the Part B deductible and coinsurance, plus

- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) and one of the following revenue codes - 096X, 097X, or 098X.

    - Use the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for all the physician/professional services rendered in a CAH that elected the all-inclusive method. The FI will pay 115 percent of whatever Medicare would pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) Payment for non physician practitioners will be 115 percent of 85 percent of the allowable amount under the physician fee schedule; and

    - Outpatient services, including ASC, rendered in an all-inclusive rate provider method should be billed using the 85X type of bill. *Non-patient laboratory specimens* are billed on bill type 14X.

        The Medicare Physician Fee Schedule (MPFS) supplementary file and the CORF Abstract File are used for payment of all physician/professional services rendered in a CAH that has elected the optional method. The data in the supplemental file will be in the same format as the abstract file.

        If a non physician (e.g., Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) renders a service, the "GF" modifier must be on the applicable line. The "GF" modifier is not to be

used for CRNA services. If a claim is received and it has the “GF” modifier for CRNA services, the claim is returned to the provider.

250.1.3 - CRNA Services (CRNA Pass-Through Exemption of 115 Percent Fee Schedule Payments for CRNA Services

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

If a CAH that meets the criteria for a pass-through exemption is interested in selecting the Method II option, it can choose this option for all outpatient professionals except the CRNA's and still retain the approved CRNAs exemption for both inpatient and outpatient professional services of CRNAs. The CAH, with an approved exemption, can choose to give up its exemption for both inpatient and outpatient professional services of CRNAs in order to include its CRNA outpatient professional services along with those of all other professional services under the Method II option. By choosing to include the CRNAs under the Method II for outpatient services, it loses its CRNA pass-through exemption for not only the outpatient CRNA services, but also the inpatient CRNA services. In this case the CAH would have to bill the Part B carrier for the CRNA inpatient professional services.

Method I

Billing requirement

TOB = 85X

Revenue Code = 37X for CRNA technical services

Value code = Blank

Reimbursement

Revenue Code 37X = CRNA technical service - Cost Reimbursement

Deductible and coinsurance apply.

Provider Billing Requirements for Method II CRNA Services

TOB = 85X

Revenue Code = 37X for CRNA Technical service

Revenue Code = 964 for CRNA Professional service

HCPCS Code = Anesthesia HCPCS code (00100 through 01999 HCPCS range)

Units = Anesthesia

Reimbursement

Revenue Code 37X for CRNA Technical = cost reimbursement

Revenue Code 964 for CRNA Professional = 50% of Allowed Amount times 115%; or

Revenue Code 964 and the "QZ" modifier for non-medically directed CRNA Professional = 80% of Allowed Amount times 115%

How to calculate payment for anesthesia claims based on the formula

Identify anesthesia claims by HCPCS code range from 00100 through 01999

Add the anesthesia code base unit and time units. The time units are calculated by dividing actual anesthesia time (Units field on the UB92) by 15. Multiply the sum of base and time units by the locality specific anesthesia conversion factor (file name below).

The Medicare program pays the CRNA 80% of this allowable charge (non-medically directed). Deductible and coinsurance apply.

If the CRNA is medically directed, pay 50% of the allowable charge. Deductible and coinsurance apply.

Base Formula

Number of minutes divided by 15, plus the base units = Sum

Sum times the conversion factor = allowed amount

Source

Number of minutes = Number of units on the claim (Units field of the UB92)

Base Units = Anesthesia HCPCS

Conversion Factor = File – MU00.@BF12390.MPFS.CY03.ANES.V1016

Record Layout for the Anesthesia Conversion Factor File

Data Element Name	Picture	Location	Length
Carrier Number	X(5)	1-5	5
Locality Number	X(2)	13-14	2
Locality Name	X(30)	19-48	30
Anesthesia CF 2002	99V99	74-77	4

Outpatient services, including ASC services, rendered in an optional method payment provider will be billed using the 85X type of bill. *Non-patient laboratory specimens are* to be billed on a 14X type of bill.

250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method by filing a written election with the intermediary at least 30 days before start of the Cost Reporting period to which the election applies. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period for the CAH.

However, the Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changes the requirement that each practitioner rendering a service at a CAH that has elected the optional method, reassign their billing rights to that CAH. This provision allows each practitioner to choose whether to reassign billing rights to the CAH or file claims for professional services through their carrier. The reassignment will remain in affect for that entire cost reporting period.

The individual practitioner must certify, using the Form CMS 855R, if he/she wishes to reassign their billing rights. The CAH must then forward a copy of the 855R to the intermediary, must have the practitioner sign an attestation that clearly states that the practitioner will not bill the carrier for any services rendered at the CAH once the reassignment has been given to the CAH. This "attestation" will remain at the CAH.

For CAHs that elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. For CAHs electing the optional method on or after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004. Under this election, a CAH will receive payment from their intermediary for professional services furnished in that CAH's outpatient department. Professional services are those furnished by all licensed professionals who otherwise would be entitled to bill the carrier under Part B.

Payment to the CAH for each outpatient visit (reassigned billing) will be the sum of the following:

- For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. On the *ANSI X12N 837 I or the hardcopy* Form *CMS-1450 (UB-92)*, list the facility service(s) rendered to outpatients using the appropriate revenue code. The FI will pay the amount equal to the lesser of 80 percent of 101 percent of the reasonable costs of its outpatient services, or the 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts, plus:
- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

- The FI uses the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for all the physician/professional services rendered in a CAH that elected the all-inclusive method. The data in the supplemental file *are* in the same format as the abstract file. The FI will pay 115 percent of whatever Medicare would pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) Payment for non physician practitioners will be 115 percent of 85 percent of the allowable amount under the physician fee schedule; and

  For a non-participating physician service, a CAH must place modifier AK on the claim. The intermediary should pay 95 percent of the payment amount for non-participating physician services. Calculating 95 percent of 115 percent of an amount is equivalent to multiplying the amount by a factor of 1.0925. To calculate the Medicare limiting charge for a physician service for a locality, multiply the fee schedule amount by a factor of 1.0925.

  Payment for non-physician practitioners will be 115 percent of the allowable amount under the physician fee schedule.

  If a non-physician practitioner renders a service, one of the following modifiers must be on the applicable line:

  GF - Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for CRNA services, the claim is returned to the provider.)

  SB - Services rendered in a CAH by a nurse midwife.

  AH - Services rendered in a CAH by a clinical psychologist.

  AE - Services rendered in a CAH by a nutrition professional/registered dietitian.

- Outpatient services, including ASC type services, rendered in an all-inclusive rate provider should be billed using the 85X type of bill (TOB). *Non-patient laboratory specimens* are billed on TOB 14X.

  The (MPFS) supplemental file is used for payment of all physician/professional services rendered in a CAH that has elected the optional method. If a HCPCS has a facility rate and a non-facility rate, pay the facility rate.

CORF SERVICES SUPPLEMENTAL FEE SCHEDULE
CRITICAL ACCESS HOSPTIAL FEE SCHEDULE

DATA SET NAMES: MU00.@BF12390.MPFS.CY05.SUPL.V1122.FI

This is the final physician fee schedule supplemental file.

RECORD LENGTH: 60

RECORD FORMAT: FB

BLOCK SIZE: 6000

CHARACTER CODE: EBCDIC

SORT SEQUENCE: Carrier, Locality HCPCS Code, Modifier

Data Element Name	Location	Picture Value	
1 - HCPCS	1-5	X(05)	
2 - Modifier	6-7	X(02)	
3 - Filler	8-9	X(02)	
4 - Non-Facility Fee	10-16	9(05)V99	
5 - Filler	17-17	X(01)	
6 - PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.
7 - Filler	19	X(1)	
8 - Facility Fee	20-26	9(05)V99	
9 - Filler	27-30	X(4)	
10 - Carrier Number	31-35	X(05)	
11 - Locality	36-37	X(02)	
12 - Filler	38-40	X(03)	
13 - Fee Indicator	41-41	X(1)	Field not populated— filled with spaces.
14 - Outpatient Hospital	42-42	X(1)	Field not populated—Filled with spaces.
15 - Status Code	43-43	X(1)	Separate instructions will be issued for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it's separately payable if the service is covered.
14 - Filler	44-60	X(17)	

If a non-physician (e.g., Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) renders a service, the "GF" modifier must be on the applicable line. **The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for CRNA services, the claim is returned to the provider.**

Health Professional Shortage Area (HPSA) Incentive Payments for Physicians

Section 1833 (m) of the Social Security Act, provides incentive payments for physicians who furnish services in areas designated as HPSAs under section 332(a)(1)(A) of the Public Health Service (PHS) Act. This statute recognizes geographic-based, primary medical care and mental health HPSAs, are areas for receiving a 10 percent bonus payment. The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating shortage areas.

Physicians, including psychiatrists, who provide covered professional services in a primary medical care HPSA, are entitled to an incentive payment. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. The bonus is payable for psychiatric services furnished in either a primary care HPSA, or a mental health HPSA. Dental HPSAs remain ineligible for the bonus payment.

Physicians providing services in either rural or urban HPSAs are eligible for a 10-percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although, frequently, this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

If the CAH electing the Optional Method (Method II) is located within a primary medical care HPSA, and/or mental health HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. Therefore, payments to such a CAH for professional services of physicians in the outpatient department will be 115 percent **times** the amount payable under fee schedule **times** 110 percent. An approved Optional Method CAH that is located in a HPSA County should notify you of its HPSA designation **in writing**. Once you receive the information, place an indicator on the provider file showing the effective date of the CAH's HPSA status. The CMS will furnish quarterly lists of mental health HPSAs to intermediaries.

The HPSA incentive payment is 10 percent of the amount actually paid, not the approved amount. Do not include the incentive payment in each claim. Create a utility file so that you can run your paid claims file for a quarterly log. From this log you will send a quarterly report to the CAHs for each physician payment, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment sent along with the report to the CAH. If any of the claims included on report are adjusted, be sure the adjustment also goes to the report. If an adjustment request is received after the end of the quarter, any related adjustment by the FI will be included on next quarter's report. CAHs must be sure to keep adequate records to permit distribution of the HPSA bonus payment when received. If an area is designated as both a mental

health HPSA and a primary medical care HPSA, only one 10 percent bonus payment shall be made for a single service.

20.2.1 - Hospital and Skilled Nursing Facility (SNF) Patients

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Carriers may not pay for the technical component (TC) of radiology services furnished to hospital patients. Payment for physicians' radiological services to the hospital, e.g., administrative or supervisory services, and for provider services needed to produce the radiology service, is made by the fiscal intermediary (FI) as a provider service.

FIs include the TC of radiology services for hospital inpatients except Critical Access Hospitals (CAH) in the prospective payment system (PPS) payment to hospitals.

For CAHs, payment is made by the FI based on reasonable cost.

Radiology and other diagnostic services furnished to hospital outpatients are paid under the Outpatient Prospective Payment System (OPPS) to the hospital. This applies to bill types 12X *and*13Xthat are submitted to the FI. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for radiology services.*

As a result of SNF Consolidated Billing (Section 4432(b) of the Balanced Budget Act (BBA) of 1997), carriers may not pay for the TC of radiology services furnished to Skilled Nursing Facility (SNF) inpatients during a Part A covered stay. The SNF must bill radiology services furnished its inpatients in a Part A covered stay and payment is included in the SNF Prospective Payment System (PPS).

Radiology services furnished to outpatients of SNFs may be billed by the supplier performing the service or by the SNF under arrangements with the supplier. If billed by the SNF, FIs pay according to the Medicare Physician Fee Schedule. SNFs submit claims to the FI with type of bill 22X or 23X.

40.1.3 - Special Billing Instructions for RHCs and FQHCs

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Independent RHCs and free-standing FQHCs bill under bill type 71X and 73X for the professional component utilizing revenue codes 520 and 521 as appropriate. HCPCS coding is not required. The technical component is outside the scope of the RHC/FQHC benefit. The provider of the technical service bills on Form CMS-1500 or electronic equivalent to the carrier.

The technical component for a provider based RHC/FQHC is typically furnished by the provider. The provider of that service bills under bill type 13X or 85X as appropriate using its outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for radiology services.*

40.1.4 – Payment Requirements

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Payment is as follows:

- Inpatient – PPS, based on the DRG
- Hospital outpatient departments – OPPS, based on the APC
- Rural health clinics/federally qualified health centers (RHCs/FQHCs) – All-inclusive rate, professional component only, based on the visit furnished to the RHC/FQHC beneficiary to receive the MRA. The technical component is outside the scope of the RHC/FQHC benefit. Therefore the provider of the technical service bills their carrier on *the ANSI X12N 837 P or hardcopy* Form CMS-1500 and payment is made under MPFS.
- Critical Access Hospital (CAH) –
    - For CAHs that elected the optional method of payment for outpatient services, the payment for technical services would be the same as the CAHs that did not elect the optional method - Reasonable cost.
    - *The FI* pays *the* professional component at 115 percent of Medicare Physician Fee Schedule (MPFS).

Deductible and coinsurance apply.

140.3 - Payment Methodology and HCPCS Coding

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Carriers pay for bone mass measurement procedures based on the Medicare physician fee schedule. Claims from physicians, other practitioners, or suppliers where assignment was not taken are subject to the Medicare limiting charge.

The FIs pay for bone mass measurement procedures under the current payment methodologies for radiology services according to the type of provider.

Deductible and coinsurance apply.

Any of the following codes may be used when billing for bone mass measurements. All of these codes are bone densitometry measurements except code 76977 which is bone sonometry measurements. Codes are applicable to billing FIs and carriers.

76070 76071 76075 76076 76078 76977 78350 G0130

The FIs are billed using *the ANSI X12N 837 I or hardcopy* Form CMS-1450 *(UB-92)*. The appropriate bill types are: 12X, 13X, 22X, 23X, 34X, 71X (Provider-based and independent), 72X, 73X (Provider-based and freestanding), 83X, and 85X. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for bone mass measurements.*

Providers who use the hard copy UB-92 (Form CMS-1450) report the applicable bill type in Form Locator (FL) 4, Type of Bill.

Providers must report HCPCS codes for bone mass measurements under revenue code 320 with number of units and line item dates of service per revenue code line for each bone mass measurement reported.

Carriers are billed for bone mass measurement procedures using *the ANSI X12N 837 P or hardcopy* Form CMS-1500.

10.2 - General Explanation of Payment

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Outpatient laboratory services can be paid in different ways:

- Physician Fee Schedule;
- Reasonable costs (Critical Access Hospitals (CAH) only);

  NOTE: When the CAH bills a 14X bill type for a *non-patient laboratory specimen*, the CAH is paid under the fee schedule
- Laboratory Fee Schedule;
- Outpatient Prospective Payment System, (OPPS) except for most hospitals in the state of Maryland that are subject to a waiver; or
- Reasonable Charge

Annually, CMS distributes a list of codes and indicates the payment method. Carriers and FIs pay as directed by this list. Neither deductible nor coinsurance applies to HCPCS codes paid under the laboratory fee schedule; further, deductible and coinsurance do not apply to HCPCS laboratory codes paid via reasonable cost to CAHs. The majority of outpatient laboratory services are paid under the laboratory fee schedule or the OPPS.

Carriers and FIs are responsible for applying the correct fee schedule for payment of clinical laboratory tests. FIs must determine which hospitals meet the criteria for payment at the 62 percent fee schedule. Only sole community hospitals with qualified hospital laboratories are eligible for payment under the 62 percent fee schedule. Generally, payment for diagnostic laboratory tests that are not subject to the clinical laboratory fee schedule is made in accordance with the reasonable charge or physician fee schedule methodologies (or reasonable costs for CAHs).

For Clinical Diagnostic Laboratory services denied due to frequency edits contractors must use standard health care adjustment reason code 151 - “Payment adjusted because the payer deems the information submitted does not support this many services.”

30.3 - Method of Payment for Clinical Laboratory Tests - Place of Service Variation

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The following apply in determining the amount of Part B payment for clinical laboratory tests, including those furnished under method II for ESRD beneficiaries:

Independent laboratory or a physician or medical group - Payment to an independent laboratory or a physician or medical group is the lesser of the actual charge, the fee schedule amount or the national limitation amount. Part B deductible and coinsurance do not apply.

Reference laboratory - For tests performed by a reference laboratory, the payment is the lesser of the actual charge by the billing laboratory, the fee schedule amount, or the national limitation amount *(NLA)*. (See §50.5 for carrier jurisdiction details.) Part B deductible and coinsurance do not apply.

Outpatient of the hospital - Payment to a hospital for *laboratory* tests *payable on the Clinical Diagnostic Laboratory Fee Schedule,* furnished *to an* outpatient of the hospital, is the lesser of the actual charge, fee schedule amount, or the NLA. Part B deductible and coinsurance do not apply. *Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS.*

Non-Patient Laboratory Specimen*-Laboratory tests payable on the Clinical Diagnostic Laboratory Fee Schedule for a non-patient laboratory specimen(bill type 14X) is the lesser of the actual charge, the fee schedule amount, or the NLA.(including CAHs and MD Waiver hospitals). Part B deductible and coinsurance do not apply. Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS.*

Inpatient without Part A - Payment to a hospital for *laboratory* tests *payable on the Clinical Diagnostic Laboratory Fee Schedule,* is the lesser of the actual charge, fee schedule amount, or the NLA. Part B deductible and coinsurance do not apply. *Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS.* Payment to a SNF inpatient without Part A coverage is made under the laboratory fee schedule.

Inpatient or SNF patient with Part A - Payment to a hospital for laboratory tests furnished to an inpatient, whose stay is covered under Part A, is included in the PPS rate for PPS facilities or is made on a reasonable cost basis for non-PPS hospitals. Payments for lab services for beneficiaries in a Part A stay in a SNF, other than a swing bed in a CAH are included in the SNF PPS rate. For such services provided in a swing bed CAH, payment is made on a reasonable cost basis.

Sole community hospital - Payment to a sole community hospital for tests furnished for an outpatient of that hospital is the least of the actual charge, the 62 percent fee schedule amount, or the 62 percent NLA. The Part B deductible and coinsurance do not apply.

Waived Hospitals - Payment for *outpatient (bill type13X)*, to a hospital which has been granted a waiver of Medicare payment principles for outpatient services is subject to Part B deductible and coinsurance unless otherwise waived as part of an approved waiver. Specifically, laboratory fee schedules do not apply to laboratory tests furnished by hospitals in States or areas that have been granted demonstration waivers of Medicare reimbursement principles for outpatient services. The State of Maryland has been granted such demonstration waivers. This also may apply to hospitals in States granted approval for alternative payment methods for paying for hospital outpatient services under §1886(c) of the Act. *Payment for non-patient laboratory specimens (bill type14X), is based on the fee schedule. Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be based on current methodology.*

Critical Access Hospital - For a CAH being reimbursed under the "Standard Method" of reimbursement (See Chapter 4), payment for clinical laboratory services furnished as an outpatient service is made on a reasonable cost basis. Critical Access Hospitals choosing the "Standard Method" are paid under the fee schedule for services *for a non-patient laboratory specimen* (bill type 14X). *Payment for non-patient laboratory specimens (bill type14X), is based on the fee schedule. Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be based on current methodology.*

CAHs choosing the "Optional Method" of reimbursement (see Chapter 4) are reimbursed at reasonable cost *for outpatient (bill type 85X)* non-professional clinical laboratory services and at 115 percent of the fee schedule for professional clinical laboratory services. *Payment for non-patient laboratory specimens (bill type14X), is based on the fee schedule. Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be based on current methodology.*

Beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to CAH clinical laboratory services.

Dialysis facility - Payment to a hospital-based or independent dialysis facility for laboratory tests included under the ESRD composite rate payment and performed for a patient of that facility, is included in the facility's composite rate payment for these tests and is subject to the Part B deductible and coinsurance. Laboratory tests that are not included under the ESRD composite rate payment; and are performed by an independent laboratory or a provider-based laboratory for dialysis patients of independent dialysis facilities or provider based facilities; are paid in addition to the composite rate payment and are subject to the fee schedule limits. This also applies to all laboratory tests furnished to home dialysis patients who have selected Payment Method II. These limits are 60 percent for all tests unless performed by a qualified hospital laboratory in a sole community hospital; in which case the 62 percent rate applies. The laboratory performing the tests must bill.

Rural health clinic - Payment to a rural health clinic (RHC) for laboratory tests performed for a patient of that clinic is not included in the all-inclusive rate and may be billed separately by the laboratory (including a laboratory that is part of a hospital that

hosts a hospital based RHC). Payment for the laboratory service is not subject to Part B deductible and coinsurance. (See §40.4 for details on RHC billing.)

Enrolled in Managed Care - Payment to a participating health maintenance organization (HMO) or health care prepayment plan (HCPP) for laboratory tests provided to a Medicare beneficiary who is an enrolled member is included in the monthly capitation amount.

Non-enrolled Managed Care - Payment to a participating HMO or HCPP for laboratory tests performed for a patient who is not a member is the lesser of the actual charge, or the fee schedule, or the NLA. The Part B deductible and coinsurance do not apply.

Hospice - Payment to a hospice for laboratory tests performed by the hospice is included in the hospice rate.

40.3 - Hospital Billing Under Part B

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)
Hospital laboratories, billing for either outpatient or non-patient claims, bill the FI. Neither deductible nor coinsurance applies to laboratory tests paid under the fee schedule.

Hospitals must follow requirements for submission of the *ANSI X12N 837 I or the hardcopy* Form CMS-1450 *(UB-92)* (see Chapter 25 for billing requirements).

When the hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the hospital can bill for the arranged services.

If the hospital is a sole community hospital identified in the PPS Provider Specific File with a qualified hospital laboratory identified on the hospital's certification; tests for outpatients are reimbursable at 62 percent.

If the hospital bills for both types of *laboratory* tests, it should prepare two bills: one *for the outpatient (13X type of bill)* laboratory test, the other for the *non-patient laboratory specimen (14X type of bill)* tests. The hospital includes fee schedule laboratory tests on the same bill with other outpatient services to the same beneficiary on the same day, unless it is billing for a *non-patient laboratory specimen* as described above, in which case it submits a separate bill for the *non-patient laboratory specimen* tests. Hospitals should not submit separate bills for laboratory tests performed in different departments on the same day.

Section 416 of the Medicare Prescription, Drug, Improvement, and Modernization Act (MMA) of 2003 also eliminates the application of the clinical laboratory fee schedule for hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area for cost reporting periods beginning during the 2-year period beginning on July 1, 2004. Payment for these hospital outpatient laboratory tests will be reasonable costs without coinsurance and deductibles during the applicable time period. A qualified rural area is one with a population density in the lowest quartile of all rural county populations.

The reasonable costs are determined using the ratio of costs to charges for the laboratory cost center multiplied by the PS&R's billed charges for outpatient laboratory services for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2006.

In determining whether clinical laboratory services are furnished as part of outpatient services of a hospital, the same rules that are used to determine whether clinical laboratory services are furnished, as an outpatient critical access hospital service will apply.

40.3.1 - Critical Access Hospital (CAH) Outpatient Laboratory Service

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Effective for services furnished on or after the enactment of Balanced Budget Refinement Act of 1999 (BBRA), Medicare beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to clinical laboratory services furnished as a CAH outpatient service. This change is effective for claims with dates of service on or after November 29, 1999, that were received July 1, 2001 or later.

For CAH bill type 85X, the laboratory fees are paid at cost with no cost-sharing.

When the CAH electing *either* the standard or *optional* reimbursement method (see chapter 3) bills a 14X bill type as a *non-patient* laboratory specimen, it is paid on the laboratory fee schedule rather than reasonable cost.

20.2.1 - Computer-Aided Detection (CAD) Add-On Codes

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Screening Add-on Codes 76085 and 76083

Effective for services on or after January 1, 2002 through December 31, 2003, (or April 1, 2002 for hospitals subject to OPPS) a new CPT code 76085, CAD conversion of standard film images to digital images has been established as an add-on code that can be billed only in conjunction with the primary service screening mammography code 76092. The definition of 76085 is: "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, mammography (list separately in addition to code for primary procedure)."

NOTE: For claims with dates of service April 1, 2003 – December 31, 2003, code G0202 may be billed in conjunction with 76085.

Carriers and FIs make payment under the Medicare physician fee schedule. There is no Part B deductible. However, coinsurance is applicable.

For claims with dates of service April 1, 2005, and later, hospitals bill for code 76083 under the 13X bill type. The 14X bill type *is* no longer applicable. Appropriate TOBs for providers other than hospitals are 22x, 23x, and 85x.

Contractors must assure that claims containing code 76085 also contain HCPCS code 76092 or G0202. If not, FIs return claims to the provider with an explanation that payment for code 76085 cannot be made when billed alone. Carriers deny payment for 76085 when billed without 76092 or G0202.

NOTE: When screening CAD 76085 is billed in conjunction with a screening mammography (76092 or G0202) and the screening mammography (76092 or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

Effective with claims with dates of service January 1, 2004 and later, HCPCS code 76083, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service mammography code 76092 or G0202.

Contractors must assure that claims containing code 76083 also contain HCPCS code 76092 or G0202. FIs return claims containing code 76083 that do not also contain HCPCS code 76092 or G0202 with an explanation that payment for code 76083 cannot be made when billed alone. Carriers deny payment for 76083 when billed without 76092 or G0202.

NOTE: When screening CAD 76083 is billed in conjunction with a screening mammography (76092 or G0202) and the screening mammography (76092 or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

Diagnostic Add-on Codes G0236 and 76082

Effective for services on or after January 1, 2002 thru December 31, 2003, (or April 1, 2002 for hospital claims subject to OPPS), HCPCS code G0236 was established for diagnostic mammography CAD that can be billed only on the same claim with the primary service of either 76090 or 76091. The definition of G0236 is: "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation." The code must be listed separately in addition to code for the primary procedure.

NOTE: For claims with dates of service April 1, 2003 - December 31, 2003, code G0204 and G0206 may be billed in conjunction with G0236.

For claims with dates of service April 1, 2005, and later, hospitals bill for code 76082 under the 13X bill type. The 14X bill type *is* no longer applicable. Appropriate TOBs for providers other than hospitals are 22x, 23x, and 85x.

There are no frequency limitations on diagnostic tests or CAD-diagnostic tests.

Contractors must assure that claims containing code G0236 also contain HCPCS code 76090, 76091, G0204, or G0206. If not, FIs return claims to the provider with an explanation that payment for code G0236 cannot be made when billed alone. Carriers deny payment for G0236 when billed without 76090, 76091, G0204 or G0206.

Effective with claims with dates of service January 1, 2004 and later, HCPCS code 76082, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service mammography code 76090, 76091, G0204, or G0206.

Contractors must assure that claims containing code 76082 also contain HCPCS codes 76090, 76091, G0204 or G0206. FIs return claims containing code 76082 that do not also contain HCPCS code 76090, 76091, G0204, or G0206 with an explanation that payment for code 76082 cannot be made when billed alone. Carriers deny payment for 76082 when billed without 76090, 76091, G0204, or G0206.

30.4.1 - Payment Method for RHCs and FQHCs

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The professional component of a screening Pap smear furnished within an RHC/FQHC by a physician or non physician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component along with revenue code 052X. See Chapter 9, for RHC and FQHC bill processing instructions.

The technical component of a screening Pap smear is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the carrier on Form CMS-1500.

If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the FI under bill type 13X, 14X, 22X, 23X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 311. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.*

30.5 - HCPCS Codes for Billing

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The following HCPCS codes can be used for screening Pap smear:

A. Codes Billed to the Carrier and Paid Under the Physician Fee Schedule

The following HCPCS codes are submitted by those providers/entities that submit claims to carriers. The deductible is waived for these services effective January 1, 1998, however, coinsurance applies.

NOTE: These codes are not billed on FI claims except for HCPCS code Q0091 which may be submitted to FIs. Payment for code Q0091 performed in a hospital outpatient department is under OPPS, (see 30.5C).

- Q0091 - Screening Papanicolaou (Pap) smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory;
- P3001 - Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by a physician;
- G0124 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician; and
- G0141 - Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual re-screening, requiring interpretation by physician.

B. Codes Paid Under the Clinical Lab Fee Schedule by FI and Carriers

The following codes are billed to FIs by providers they serve, or billed to carriers by the physicians/suppliers they service. Deductible and coinsurance do not apply.

- P3000 - Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision;
- G0123 - Screening cytopathology, cervical or vaginal (any reporting system) collected in preservative fluid; automated thin layer preparation, screening by cytotechnologist under physician supervision;
- G0143 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and re-screening, by cytotechnologist under physician supervision.;
- G0144 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system under physician supervision;
- G0145 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual re-screening under physician supervision;
- G0147 - Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision; and

- G0148 - Screening cytopathology smears, cervical or vaginal, performed by automated system with manual reevaluation.

C. Payment of Q0091 When Billed to FIs

Payment for code Q0091 in a hospital outpatient department is under OPPS. A SNF is paid using the technical component of the MPFS. For a CAH, payment is on a reasonable cost basis. For RHC/FQHCs payment is made under the all inclusive rate for the professional component. Deductible is not applicable, however, coinsurance applies.

The technical component of a screening Pap smear is outside the RHC/FQHC benefit. If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the FI under the bill type 13X, 14X,22X, 23X, or 85X as appropriate using their base provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). For independent RHCs/FQHCs, the practitioner bills the technical component to the carrier on Form CMS-1500 or *the ANSI X12N* 837 P. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.*

D. Payment of Q0091 When Billed to Carriers

Payment for Q0091 is paid under the Medicare physician fee schedule. Deductible is not applicable, however the coinsurance applies.

Effective for services on and after July 1, 2005, on those occasions when physicians must perform a screening Pap smear (Q0091) that they know will not be covered by Medicare because the low risk patient has already received a covered Pap smear (Q0091) in the past 2 years, the physician can bill Q0091 and the claim will be denied appropriately. The physician shall obtain an advance beneficiary notice (ABN) in these situations as the denial will be considered a not reasonable and necessary denial. The physician indicates on the claim that an ABN has been obtained by using the GA modifier.

Effective for services on or after April 1, 1999, a covered evaluation and management (E/M) visit and code Q0091 may be reported by the same physician for the same date of service if the E/M visit is for a separately identifiable service. In this case, the modifier "-25" must be reported with the E/M service and the medical records must clearly document the E/M reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately on separate office visits.

E. Common Working File (CWF) Editing for Q0091

The CWF will edit for claims containing the HCPCS code Q0091 effective for dates of service on and after July 1, 2005. Previously, the editing for Q0091 had been removed from the CWF. Medicare pays for a screening Pap smear every 2 years for low risk patients based on the low risk diagnoses, see sections 30.2 and 30.6. Medicare pays for a screening Pap smear every year for a high risk patient based on the high risk diagnosis, see sections 30.1 and 30.6. This criteria will be the CWF parameters for editing Q0091.

In those situations where unsatisfactory screening Pap smear specimens have been collected and conveyed to clinical labs that are unable to interpret the test results, another specimen will have to be collected. When the physician bills for this reconveyance, the

physician should annotate the claim with Q0091 along with modifier -76, (repeat procedure by same physician).

30.7 - Type of Bill and Revenue Codes for Form CMS-1450

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The applicable bill types for screening Pap smears are 13X, 14X, 22X, 23X, and 85X. Use revenue code 0311 (laboratory, pathology, cytology). Report the screening pap smear as a diagnostic clinical laboratory service using one of the HCPCS codes shown in §30.5.B.

Revenue code 0928 is used for billing code Q0091. In addition, CAHs electing method II report services under revenue codes 096X, 097X, or 098X.

Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.

40.6 - Revenue Code and HCPCS Codes for Billing

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

A. Billing to the Carrier

Code G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination) is used.

Effective for services on or after January 1, 1999, a covered evaluation and management (E/M) visit and code G0101 may be reported by the same physician for the same date of service if the E/M visit is for a separately identifiable service. In this case, the modifier "-25" must be reported with the E/M service and the medical records must clearly document the E/M service reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately on separate office visits.

B. Billing to the FI

The applicable bill types for a screening pelvic examination (including breast examination) are 13X, ~~*14X,*~~ 22X, 23X, and 85X. The applicable revenue code is 0770. (See §70.1.1.2 for RHCs and FQHCs.) *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for a screening pelvic examination.*

The professional component of a screening pelvic examination furnished within an RHC/FQHC by a physician or non-physician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component along with revenue code 052X.

The technical component of a screening pelvic examination is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the carrier on *ANSI X12N 837 P or hardcopy Form CMS-1500.*

If the technical component of a screening pelvic examination is furnished within a provider-based RHC/FQHC, the provider of that service bills the FI under bill type 13X, ~~*14X,*~~ 22X, 23X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 0770. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for a screening pelvic examination.*

50.3 - Payment Method - FIs and Carriers

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Screening PSA tests (G0103) are paid under the clinical diagnostic lab fee schedule.

Screening rectal examinations (G0102) are paid under the MPFS except for the following bill types identified (FI only). Bill types not identified are paid under the MPFS.

12X = Outpatient Prospective Payment System

13X = Outpatient Prospective Payment System

14X-=Outpatient Prospective Payment System

71X = Included in All Inclusive Rate

73X = Included in All Inclusive Rate

85X = Cost (Payment should be consistent with amounts paid for code 84153 or code 86316.)

Effective 4/1/06 the type of bill 14X is for non-patient laboratory specimens.

The RHCs and FQHCs should include the charges on the claims for future inclusion in encounter rate calculations.

50.4 - HCPCS, Revenue, and Type of Service Codes

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The appropriate bill types for billing the FI on Form CMS-1450 or its electronic equivalent are 12X, 13X, 14X,22X, 23X, 71X, 73X, 75X, and 85X. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.*

The HCPCS code G0102 - for prostate cancer screening digital rectal examination.

- Carrier TOS is 1
- FI revenue code is 0770

The HCPCS code G0103 - for prostate cancer screening PSA tests

- Carrier TOS is 5
- FI revenue code is 030X

10.1 - Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

A. Coding Applicable to Local Carriers & Fiscal Intermediaries (FIs)

Effective April 1, 2002, a National Coverage Decision was made to allow for Medicare coverage of ABPM for those beneficiaries with suspected "white coat hypertension" (WCH). ABPM involves the use of a non-invasive device, which is used to measure blood pressure in 24-hour cycles. These 24-hour measurements are stored in the device and are later interpreted by a physician. Suspected "WCH" is defined as: (1) Clinic/office blood pressure >140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit; (2) At least two documented separate blood pressure measurements taken outside the clinic/office which are < 140/90 mm Hg; and (3) No evidence of end-organ damage. ABPM is not covered for any other uses. Coverage policy can be found in Medicare National Coverage Determinations Manual, Chapter 1, Section 20.19. (www.cms.hhs.gov/masnuals/103 cov determ/ncd103index.asp)

The ABPM must be performed for at least 24 hours to meet coverage criteria. Payment is not allowed for institutionalized beneficiaries, such as those receiving Medicare covered skilled nursing in a facility. In the rare circumstance that ABPM needs to be performed more than once for a beneficiary, the qualifying criteria described above must be met for each subsequent ABPM test.

Effective dates for applicable Common Procedure Coding System (HCPCS) codes for ABPM for suspected WCH and their covered effective dates are as follows:

HCPCS	Definition	Effective Date
93784	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report.	04/01/2002
93786	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only.	04/01/2002
93788	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.	01/01/2004

HCPCS Definition Effective Date

93790	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report.	04/01/2002

In addition, the following diagnosis code must be present:

Diagnosis Code	Description
796.2	Elevated blood pressure reading without diagnosis of hypertension.

B. FI Billing Instructions

The applicable types of bills acceptable when billing for ABPM services are 13X, 23X, 71X, 73X, 75X, and 85X. Chapter 25 of this manual provides general billing instructions that must be followed for bills submitted to FIs. The FIs pay for hospital outpatient ABPM services billed on a 13X type of bill with HCPCS 93786 and/or 93788 as follows: (1) Outpatient Prospective Payment System (OPPS) hospitals pay based on the Ambulatory Payment Classification (APC); (2) non-OPPS hospitals (Indian Health Services Hospitals, Hospitals that provide Part B services only, and hospitals located in American Samoa, Guam, Saipan and the Virgin Islands) pay based on reasonable cost, except for Maryland Hospitals which are paid based on a percentage of cost. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for ABPM.*

The FIs pay for comprehensive outpatient rehabilitation facility (CORF) ABPM services billed on a 75x type of bill with HCPCS code 93786 and/or 93788 based on the Medicare Physician Fee Schedule (MPFS) amount for that HCPCS code.

The FIs pay for ABPM services for critical access hospitals (CAHs) billed on a 85x type of bill as follows: (1) for CAHs that elected the Standard Method and billed HCPCS code 93786 and/or 93788, pay based on reasonable cost for that HCPCS code; and (2) for CAHs that elected the Optional Method and billed any combination of HCPCS codes 93786, 93788 and 93790 pay based on reasonable cost for HCPCS 93786 and 93788 and pay 115% of the MPFS amount for HCPCS 93790.

The FIs pay for ABPM services for skilled nursing facility (SNF) outpatients billed on a 23x type of bill with HCPCS code 93786 and/or 93788, based on the MPFS.

The FIs accept independent and provider-based rural health clinic (RHC) bills for visits under the all-inclusive rate when the RHC bills on a 71x type of bill with revenue code 052x for providing the professional component of ABPM services. The FIs should not make a separate payment to a RHC for the professional component of ABPM services in addition to the all-inclusive rate. RHCs are not required to use ABPM HCPCS codes for professional services covered under the all-inclusive rate.

The FIs accept free-standing and provider-based federally qualified health center (FQHC) bills for visits under the all-inclusive rate when the FQHC bills on a 73x type of bill with revenue code 052x for providing the professional component of ABPM services.

The FIs should not make a separate payment to a FQHC for the professional component of ABPM services in addition to the all-inclusive rate. FQHCs are not required to use ABPM HCPCS codes for professional services covered under the all-inclusive rate.

The FIs pay provider-based RHCs/FQHCs for the technical component of ABPM services when billed under the base provider's number using the above requirements for that particular base provider type, i.e., a OPPS hospital based RHC would be paid for the ABPM technical component services under the OPPS using the APC for code 93786 and/or 93788 when billed on a 13x type of bill.

Independent and free-standing RHC/FQHC practitioners are only paid for providing the technical component of ABPM services when billed to the carrier following the carrier instructions.

C. Carrier Claims

Local carriers pay for ABPM services billed with diagnosis code 796.2 and HCPCS codes 93784 or for any combination of 93786, 93788 and 93790, based on the MPFS for the specific HCPCS code billed.

D. Coinsurance and Deductible

The FIs and local carriers shall apply coinsurance and deductible to payments for ABPM services except for services billed to the FI by FQHCs. For FQHCs only co-insurance applies.

12.3 - FI Billing Requirements

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Effective for dates of service on and after July 5, 2005, FIs shall recognize the HCPCS codes in 12.1 for Smoking and Tobacco-Use Cessation Counseling services.

A. Claims for Smoking and Tobacco-Use Cessation Counseling Services should be submitted on Form CMS-1450 or its electronic equivalent.

The applicable bill types are 12X, 13X, 22X, 23X, 34X, 71X, 73X, 74X, 75X, 83X, and 85X. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for Smoking and Tobacco-Use Cessation Counseling services.*

Applicable revenue codes are as follows:

Provider Type	Revenue Code
Rural Health Centers (RHCs)/Federally Qualified Health Centers (FQHCs)	052X
Indian Health Services (IHS)	0510
Critical Access Hospitals (CAHs) Method II	096X, 097X, 098X
All Other Providers	0942

NOTE: When these services are provided by a Clinical Nurse Specialist in the RHC/FQHC setting, they are considered “incident to” and do not constitute a billable visit.

Payment for outpatient services is as follows:

Type of Facility	Method of Payment
Rural Health Centers (RHCs)/Federally Qualified Health Centers (FQHCs)	All-inclusive rate (AIR) for the encounter
Indian Health Service (IHS)/Tribally owned or operated hospitals and hospital- based facilities	All-inclusive rate (AIR)
IHS/Tribally owned or operated non-hospital-based facilities	Medicare Physician Fee Schedule (MPFS)
IHS/Tribally owned or operated Critical Access Hospitals (CAHs)	Facility Specific Visit Rate
Hospitals subject to the Outpatient Prospective Payment System (OPPS)	Ambulatory Payment Classification (APC)

Hospitals not subject to OPPS	Payment is made under current methodologies
Skilled Nursing Facilities (SNFs) Note: Included in *P*art A PPS for skilled patients.	Medicare Physician Fee Schedule (MPFS)
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	Medicare Physician Fee Schedule (MPFS)
Home Health Agencies (HHAs)	Medicare Physician Fee Schedule (MPFS)
Critical Access Hospitals (CAHs)	Method I: Technical services are paid at 101% of reasonable cost. Method II: technical services are paid at 101% of reasonable cost, and Professional services are paid at 115% of the MMPFS Data Base
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC). That is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

NOTE: Inpatient claims submitted with Smoking and Tobacco-Use Cessation Counseling Services are processed under the current payment methodologies.

40.3 – Bill Types

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The applicable bill types for test stimulation procedures are 13X, 71X, 73X, 75X and 85X.

The RHCs and FQHCs bill you under bill type 71X and 73X for the professional component. The technical component is outside the scope of the RHC/FQHC benefit. The provider of that technical service bills their carrier on Form CMS-1500 or electronic equivalent.

The technical component for a provider-based RHC/FQHC is typically furnished by the provider. The provider of that service bills you under bill type 13X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services.) *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for test stimulation procedures.*

The applicable bill types for implantation procedures and devices are 11X, 13X, and 85X.