CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 428 **Date: JANUARY 14, 2005**

CHANGE REQUEST 3640

SUBJECT: Update to Billing Requirements for FDG-PET Scans for Use in the Differential Diagnosis of Alzheimer's Disease (AD) and Fronto-Temporal Dementia (FTD) and Update to the FI Billing Requirements for Special Payment Procedures for ALL PET Scan Claims for Services Performed in a Critical Access Hospital (CAH)

I. SUMMARY OF CHANGES: This CR revises billing requirements for CR 3426, Transmittal # 24, dated October 1, 2004; PET Scans for AD by removing the edit for one scan per beneficiary's lifetime for PET AD Scans and to add requirements for specifying ICD-9 diagnosis coding. Section 60.1 of the IOM is also being updated to include specific payment information for claims for all PET Scans for services submitted by Critical Access Hospitals (CAHs). All other information regarding coverage and billing for FDG-PET Scans for Use in the Differential Diagnosis of Alzheimer's Disease (AD) and Fronto-Temporal Dementia (FTD) remains the same.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: September 15, 2004
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	13/60.1/Billing Instructions
R	13/60.12/Coverage for PET Scans for Dementia and Neurodegenerative Diseases

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements

	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 428	Date: January 14, 2005	Change Request 3640

SUBJECT: Update to Billing Requirements for FDG-PET Scans for Use in the Differential Diagnosis of Alzheimer's Disease (AD) and Fronto-Temporal Dementia (FTD) and Update to the FI Billing Requirements for Special Payment Procedures for ALL PET Scan Claims for Services Performed in a Critical Access Hospital (CAH)

I. GENERAL INFORMATION

This instruction updates Publication 100-04, chapter 13, section 60, by providing general Medicare coverage and billing requirements for PET Scans for dementia and neurodegenerative diseases. Refer to Publication 100-03, National Coverage Determinations (NCD) Manual, section 220.6.13, for complete coverage policy.

A. Background: The billing requirements for 2-deoxy-2- [F-18] fluoro-D-glucose Positron Emission Tomography (FDG-PET) scans for a differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease have been updated to reflect the following:

- The editing requirement for one PET scan per beneficiary's lifetime has been removed;
- A list of appropriate ICD-9 diagnosis codes that must be identified on claims has been added; and
- The payment method for ALL PET scan claims submitted for services provided in CAHs has been added.

All other billing requirements for PET scans for dementia and neurodegenerative diseases remain the same as per CR 3426, Transmittal 24, dated October 1, 2004. Further billing information can be found in Publication 100-04, chapter 13, section 60.

B. Policy: NCD Manual, section 220.6.13

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "Medlearn Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3640.1	Effective for services on or after September 15, 2004, Medicare systems shall allow HCPCS G0336 to be billed more than once in a beneficiary's lifetime.								X	
3640.2	Effective for services on or after September 15, 2004, Medicare contractors shall ensure one of the appropriate diagnosis codes listed below is present on the claim with HCPCS G0336: 290.0, 290.10 - 290.13, 290.20 – 290.21, 290.3. 331.0, 331.11, 331.19, 331.2, 331.9. 780.93	X		X		X				
3640.2.1	Contractors shall not search and adjust claims that have already been processed unless brought to their attention.	X		X						
3640.3	Medicare systems shall deny line items with HCPCS code G0336 if one of the following diagnoses is not present: 290.0, 290.10-290.13, 290.20-290.21, 290.3, 331.0, 331.11, 331.19, 331.2, 331.9, 780.93	X		X		X				
3640.4	Medicare contractors shall use an appropriate MSN message such as 16.48 and claim adjustment reason code 11 to deny claims when submitted with HCPCS code G0336 with a diagnosis code other than the range of codes delineated in Business Requirement 3640.2.	X		X						
3640.5	Medicare contractors shall pay claims submitted for ALL PET Scan services provided by a Critical Access Hospital (CAH) as follows: Method 1, 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 Medicare Physician Fee Schedule Data Base.	X								

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3640.6	Medicare contractors shall instruct providers, via a Medlearn Matters article, of the new billing and payment requirements for PET Scans for AD contained in this document and in Publication 100-04, Chapter 13, Section 60.	X		X						
3640.7	Medicare contractors shall instruct providers via a Medlearn Matters article to issue an Advanced Beneficiary Notice to beneficiaries advising them of potential financial liability if one of the appropriate diagnosis codes is not present on the claim.	X		X						

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions
3640.1	Pub. 100-03 NCD Manual, section 220.6.13 and Pub. 100-4 Medicare Claims Processing Manual, chapter 13, section 60.12
3640.5	Pub. 100-4 Medicare Claims Processing Manual, chapter 3, section 30.1.1 and Chapter 4, Section 250.
3640.4	MSN message 16.48 "Medicare does not pay for this item or service for this condition." Claim adjustment reason code 11 "The diagnosis is inconsistent with the procedure."
3640.7	Pub 100.04, Medicare Claims Processing Manual, chapter 1. section 60.4.1. and 60.4.2

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

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: September 15, 2004 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Yvette Cousar (410) 786-2160 (carrier claims processing); Kelly Buchanan (410) 786-66132 (institutional claims processing); Samantha Richardson (410) 786-6940 (coverage policy) **Post-Implementation Contact(s):** Appropriate regional office	**Medicare contractors shall implement these instructions within their current operating budgets.**

*__Unless otherwise specified, the effective date is the date of service.__

60.1 - Billing Instructions

(Rev. 428, Issued: 01-14-05, Effective: 09-15-04, Implementation: 04-04-05)

A. Billing and Payment Instructions or Responsibilities for Carriers

Claims for PET scan services must be billed on Form-CMS 1500 or the electronic equivalent with the appropriate HCPCS and diagnosis codes to the local carrier. Effective for claims received on or after July 1, 2001, PET modifiers were discontinued and are no longer a claims processing requirement for PET scan claims. Therefore, July 1, 2001, and after the MSN messages regarding the use of PET modifiers can be discontinued. The type of service (TOS) for the new PET scan procedure codes is TOS 4, Diagnostic Radiology. Payment is based on the Medicare Physician Fee Schedule.

B. Billing and Payment Instructions or Responsibilities for FIs

Claims for PET scan procedures must be billed to the FI on Form CMS-1450 (UB-92) or the electronic equivalent with the appropriate diagnosis and HCPCS "G" codes to indicate the conditions under which a PET scan was done. These codes represent the technical component costs associated with these procedures when furnished to hospital and SNF outpatients. They are paid as follows:

- under OPPS for hospitals subject to OPPS
- under current payment methodologies for hospitals not subject to OPPS
- on a reasonable cost basis for critical access hospitals.
- on a reasonable cost basis for skilled nursing facilities.

Institutional providers bill these codes under Revenue Code 0404 (PET Scan).

Medicare contractors shall pay claims submitted for services provided by a critical cccess hospital (CAH) as follows: 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 Medicare Physician Fee Schedule Data Base.

C - Frequency

In the absence of national frequency limitations, for all indications covered on and after July 1, 2001, contractors can, if necessary, develop frequency limitations on any or all covered PET scan services.

D - Post-Payment Review for PET Scans

As with any claim, but particularly in view of the limitations on this coverage, Medicare may decide to conduct post-payment reviews to determine that the use of PET scans is consistent with coverage instructions. Pet scanning facilities must keep patient record information on file for each Medicare patient for whom a PET scan claim is made. These medical records can be used in any post-payment reviews and must include the information necessary to substantiate the need for the PET scan. These records must include standard information (e.g., age, sex, and height) along with sufficient patient histories to allow determination that the steps required in the coverage instructions were followed. Such information must include, but is not limited to, the date, place and results of previous diagnostic tests (e.g., cytopathology and surgical pathology reports, CT), as well as the results and reports of the PET scan(s) performed at the center. If available, such records should include the prognosis derived from the PET scan, together with information regarding the physician or institution to which the patient proceeded following the scan for treatment or evaluation. The ordering physician is responsible for forwarding appropriate clinical data to the PET scan facility.

Effective for claims received on or after July 1, 2001, CMS no longer requires paper documentation to be submitted up front with PET scan claims. Contractors shall be aware and advise providers of the specific documentation requirements for PET scans for dementia and neurodegenerative diseases. This information is outlined in section 60.12. Documentation requirements such as physician referral and medical necessity determination are to be maintained by the provider as part of the beneficiary's medical record. This information must be made available to the carrier or FI upon request of additional documentation to determine appropriate payment of an individual claim.

60.12 Coverage for PET Scans for Dementia and Neurodegenerative Diseases

(Rev. 428, Issued: 01-14-05, Effective: 09-15-04, Implementation: 04-04-05)

Effective for dates of service on or after September 15, 2004, Medicare will cover FDG PET scans for a differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease OR; its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases. Refer to Pub. 100-03 (National Coverage Determinations (NCD) Manual), section 220.6.13, for complete coverage conditions and clinical trial requirements.

A. Carrier and FI Billing Requirements for Pet Scan Claims for FDG-PET for the Differential Diagnosis of Fronto-temporal Dementia and Alzheimer's Disease:

- HCPCS Code for PET Scans for Dementia and Neurodegenerative Diseases

-- G0336: PET imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. fronto-temporal dementia

Short Descriptor: PET imaging brain Alzheimer's

Type of Service: 4 (Used by Carriers)

G0336 is paid under the Medicare physician fee schedule; it is a carrier-priced service.

- ***Diagnosis Codes for PET Scans for Dementia and Neurodegenerative Diseases***

The contractor shall ensure one of the following appropriate diagnosis codes is present on claim for PET Scans for AD:

-- 290.0, 290.10 - 290.13, 290.20 - 290,21, 290.3, 331.0, 331.11, 331.19, 331.2, 331.9, 780.93

Medicare contractors shall use an appropriate Medicare Summary Notice (MSN) such as 16.48, "Medicare does not pay for this item or service for this condition" to deny claims when submitted with HCPCS G0336 with a diagnosis code other than the range of codes listed above. Also, contractors shall use an appropriate Remittance Advice (RA) such as 11, " The diagnosis is inconsistent with the procedure."

Medicare contractors shall instruct providers to issue an Advanced Beneficiary Notice to beneficiaries advising them of potential financial liability if one of the appropriate diagnosis codes is not present on the claim.

- **Provider Documentation Required with the PET Scan Claim (G0336)**

Medicare contractors shall inform providers to ensure the conditions mentioned in the NCD Manual, section 220.6.13, have been met. The information must also be maintained in the beneficiary's medical record:

-- Date of onset of symptoms;
-- Diagnosis of clinical syndrome (normal aging, mild cognitive impairment or MCI: mild, moderate, or severe dementia);
-- Mini mental status exam (MMSE) or similar test score;
-- Presumptive cause (possible, probably, uncertain AD);
-- Any neuropsychological testing performed;
-- Results of any structural imaging (MRI, CT) performed;
-- Relevant laboratory tests (B12, thyroid hormone); and,
-- Number and name of prescribed medications.

B. Carrier and FI Billing Requirements for FDG-PET Scans Claims for CMS-Approved Neurodegenerative Disease Practical Clinical Trials

- **Carriers and FIs**

Contractors should not receive claims for this service until the clinical trial centers have been identified. Once these centers are identified, CMS will list the centers on the CMS Web site.

- **Carriers Only**

Carriers shall pay claims PET Scan G0336 for beneficiaries participating in a CMS-approved clinical trial submitted with the **QV**modifier. Refer to Pub. 100-03, NCD Manual, section 220.6.13, for complete policy and clinical trial requirements.

- **FIs Only**

In order to pay claims for PET scans on behalf of beneficiaries participating in a CMS-approved clinical trial, FIs require providers to submit claims with ICD-9 code V70.7 in the second diagnosis position on the Form CMS-1450 (UB-92), or the electronic equivalent, with the appropriate principal diagnosis code and HCPCS code G0336. Refer to Publication 100-03, NCD Manual, section 220.6.13, for complete coverage policy and clinical trial requirements.