

The Guide to
**Medicare
 Preventive
 Services**

for Physicians, Providers, Suppliers, and Other Health Care Professionals

Errata Sheet

Errata Sheet Release Date: March 2007

Please note that since the May 2005 version of *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* was printed, the following corrections or changes have been identified. Please keep the latest version of the errata sheet with your hard copy of the May 2005 guide. The online version of this guide may be reprinted or redistributed as needed. This errata sheet will be updated quarterly or more frequently when deemed necessary.

Medicare Expands Preventive Benefits for Seniors

Page Number	Section Title and/or Number	Description of Change
ii	1 st paragraph, 3 rd sentence	Change "contributed" to "attributed".

Initial Preventive Physical Examination

Page Number	Section Title and/or Number	Description of Change														
3	Education, counseling, and referral for other preventive services	Effective 01/01/2007: Add the following bullet to the list: <ul style="list-style-type: none"> • Ultrasound screening for Abdominal Aortic Aneurysm (AAA) See <i>MLN Matters</i> article MM5235 (2006) and/or CR 5235. 														
4	Coding and Diagnosis Information	HCPCS codes G0367 and G0368, delete from both code descriptors – "Electrocardiogram, routine ECG with at least 12 leads..."														
6	Types of Bills for FIs Table 2	Replace Table 2 in its entirety with the following table: <table border="1" style="margin-left: 20px;"> <thead> <tr> <th>Facility Type</th> <th>Type of Bill</th> </tr> </thead> <tbody> <tr> <td>Hospital Inpatient Part B including Critical Access Hospitals (CAHs)</td> <td>12X</td> </tr> <tr> <td>Hospital Outpatient</td> <td>13X</td> </tr> <tr> <td>Skilled Nursing Facility (SNF) Inpatient Part B</td> <td>22X</td> </tr> <tr> <td>Rural Health Clinic (RHC)</td> <td>71X</td> </tr> <tr> <td>Federally Qualified Health Center (FQHC)</td> <td>73X</td> </tr> <tr> <td>CAH Outpatient*</td> <td>85X</td> </tr> </tbody> </table> Revise 2 nd Note to: Effective April 1, 2005, RHCs and FQHCs no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter, 052X, or 0900. See <i>Claims Processing Manual, Chapter 9, Sections 100, 110 & 120.</i>	Facility Type	Type of Bill	Hospital Inpatient Part B including Critical Access Hospitals (CAHs)	12X	Hospital Outpatient	13X	Skilled Nursing Facility (SNF) Inpatient Part B	22X	Rural Health Clinic (RHC)	71X	Federally Qualified Health Center (FQHC)	73X	CAH Outpatient*	85X
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Federally Qualified Health Center (FQHC)	73X															
CAH Outpatient*	85X															
7	Special Billing Instructions for RHCs/FQHCs	Effective 07/01/06: Add to last bullet: RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520. See <i>MM4210 (2006) and/or CR 4210.</i>														

Cardiovascular Screening Blood Tests

Page Number	Section Title and/or Number	Description of Change														
16	Types of Bills for FIs Table 3	Replace Table 3 in its entirety with the following table. See MM3835 (2005) and/or CR 3835 (regarding TOB 14X).														
		<table border="1"> <thead> <tr> <th>Facility Type</th> <th>Type of Bill</th> </tr> </thead> <tbody> <tr> <td>Hospital Inpatient Part B including Critical Access Hospitals (CAHs)</td> <td>12X</td> </tr> <tr> <td>Hospital Outpatient</td> <td>13X</td> </tr> <tr> <td>Hospital Non-patient Laboratory Specimens including CAHs</td> <td>14X</td> </tr> <tr> <td>Skilled Nursing Facility (SNF) Inpatient Part B</td> <td>22X</td> </tr> <tr> <td>SNF Outpatient</td> <td>23X</td> </tr> <tr> <td>CAH</td> <td>85X</td> </tr> </tbody> </table>	Facility Type	Type of Bill	Hospital Inpatient Part B including Critical Access Hospitals (CAHs)	12X	Hospital Outpatient	13X	Hospital Non-patient Laboratory Specimens including CAHs	14X	Skilled Nursing Facility (SNF) Inpatient Part B	22X	SNF Outpatient	23X	CAH	85X
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Diabetes Screening Tests, Supplies, Self-Management Training, and Other Services

Page Number	Section Title and/or Number	Description of Change														
21	Risk Factors, 4 th bullet	Change "intolerance" to "tolerance".														
24	Types of Bills for FIs Table 2	Replace Table 2 in its entirety with the following table. See MM3835 (2005) and/or CR 3835 (regarding TOB 14X).														
		<table border="1"> <thead> <tr> <th>Facility Type</th> <th>Type of Bill</th> </tr> </thead> <tbody> <tr> <td>Hospital Inpatient Part B including Critical Access Hospitals (CAHs)</td> <td>12X</td> </tr> <tr> <td>Hospital Outpatient</td> <td>13X</td> </tr> <tr> <td>Hospital Non-patient Laboratory Specimens including CAHs</td> <td>14X</td> </tr> <tr> <td>Skilled Nursing Facility (SNF) Inpatient Part B</td> <td>22X</td> </tr> <tr> <td>SNF Outpatient</td> <td>23X</td> </tr> <tr> <td>CAH Outpatient</td> <td>85X</td> </tr> </tbody> </table>	Facility Type	Type of Bill	Hospital Inpatient Part B including Critical Access Hospitals (CAHs)	12X	Hospital Outpatient	13X	Hospital Non-patient Laboratory Specimens including CAHs	14X	Skilled Nursing Facility (SNF) Inpatient Part B	22X	SNF Outpatient	23X	CAH Outpatient	85X
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27	Procedure Codes and Descriptors Table 4	Replace Table 4 with the following table:														
		<table border="1"> <thead> <tr> <th>HCPCS Codes</th> <th>HCPCS Code Descriptors</th> </tr> </thead> <tbody> <tr> <td>A5512</td> <td>For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each</td> </tr> <tr> <td>A5513</td> <td>For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each</td> </tr> </tbody> </table>	HCPCS Codes	HCPCS Code Descriptors	A5512	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each	A5513	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each								
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34	Types of Bills for FIs Table 7	Change 1st row of table, under Facility Type, from "Hospital Inpatient Part B" to "Hospital Inpatient Part B including Critical Access Hospitals (CAHs)"; change last row under Facility Type from "Critical Access Hospital (CAH)" to "CAH Outpatient". Add new row to bottom of table: Facility Type: Federally Qualified Health Center (FQHC); Type of Bill: 73X; Revenue Code: 052X. See MM4385 (2006) and/or CR 4385.														

Diabetes Screening Tests, Supplies, Self-Management Training, and Other Services (Cont.)

Page Number	Section Title and/or Number	Description of Change									
37	Procedure Codes and Descriptors Table 9	<p>Add the following rows to Table 9:</p> <table border="1"> <thead> <tr> <th>HCPCS/CPT Codes</th> <th>Instructions for Use</th> </tr> </thead> <tbody> <tr> <td>G0270 & G0271</td> <td>These codes are to be used when additional hours of MNT services are performed beyond the number of hours typically covered when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary.</td> </tr> </tbody> </table> <p><i>See Claims Processing Manual, Chapter 4, Section 300.4.</i></p>	HCPCS/CPT Codes	Instructions for Use	G0270 & G0271	These codes are to be used when additional hours of MNT services are performed beyond the number of hours typically covered when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary.					
HCPCS/CPT Codes	Instructions for Use										
G0270 & G0271	These codes are to be used when additional hours of MNT services are performed beyond the number of hours typically covered when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary.										
38	Diagnosis Requirements	<p>1st paragraph, change to: "Medical Nutrition Therapy services are available for beneficiaries with diabetes or renal disease. The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease." <i>See MM3955 (2005) and/or CR 3955.</i></p> <p>Revise last sentence to: Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [Glomerular Filtration Rate (GFR) 13-50 ml/min/1.73m²]. <i>See Claims Processing Manual, Chapter 4, Section 300.</i></p>									
38	Types of Bills for FIs Table 10	<p>Add the following rows to Table 10:</p> <table border="1"> <thead> <tr> <th>Facility Type</th> <th>Type of Bill</th> <th>Revenue Code</th> </tr> </thead> <tbody> <tr> <td>Skilled Nursing Facility Outpatient (SNF)</td> <td>23X</td> <td>0942</td> </tr> <tr> <td>Home Health Agency (HHA) (Not under an HHA plan of care)</td> <td>34X</td> <td>0942</td> </tr> </tbody> </table>	Facility Type	Type of Bill	Revenue Code	Skilled Nursing Facility Outpatient (SNF)	23X	0942	Home Health Agency (HHA) (Not under an HHA plan of care)	34X	0942
Facility Type	Type of Bill	Revenue Code									
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39	Diabetic Supplies and Services box	<p>1st paragraph, change to: "The Medicare Fee-for-Service Program may not cover all supplies and equipment for beneficiaries with diabetes. The following may be excluded:"</p> <p>Delete "prescription drugs" and "routine or yearly physical exams" from the list.</p> <p>Add sentence: "Contact your local Medicare Contractor for more information on coverage exclusions."</p>									

Mammography Screening

Page Number	Section Title and/or Number	Description of Change												
Throughout chapter	Throughout chapter	Change chapter tab/title to read "Screening Mammography".												
45	Coverage Information	Revise 2 nd Note to: Mammography services must be provided in a Food and Drug Administration (FDA) or a State/Mammography Quality Standards Act (MQSA) certified radiological facility and the results must be interpreted by a qualified physician who is directly associated with the facility at which the mammogram was taken.												
45	Procedure Codes and Descriptors Table 1	<p>Effective 01/01/2007:</p> <table border="1"> <thead> <tr> <th>Delete CPT Code</th> <th>Replace With New CPT Code</th> </tr> </thead> <tbody> <tr> <td>76082</td> <td>77051</td> </tr> <tr> <td>76083</td> <td>77052</td> </tr> <tr> <td>76090</td> <td>77055</td> </tr> <tr> <td>76091</td> <td>77056</td> </tr> <tr> <td>76092</td> <td>77057</td> </tr> </tbody> </table> <p><i>See MM5327 (2006) and/or CR 5327.</i></p>	Delete CPT Code	Replace With New CPT Code	76082	77051	76083	77052	76090	77055	76091	77056	76092	77057
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Mammography Screening (Cont.)

Page Number	Section Title and/or Number	Description of Change												
47	Billing Requirements	<p>Effective 01/01/2007: 3rd paragraph - 1st sentence, change to: When submitting a claim for a screening mammogram and a diagnostic mammogram for the same beneficiary on the same day, attach modifier GG to the diagnostic mammogram (CPT codes 77055 and 77056 or HCPCS codes G0204 or G0206). 4th paragraph, change to: Payment for the Computer-Aided Detection (CAD) mammography codes 77051 and 77052 cannot be made if billed alone. If the beneficiary receives CAD mammography as part of a Medicare screening or diagnostic mammography service, the CAD codes must be billed in conjunction with primary service codes (Table 1). See <i>MM5327 (2006) and/or CR 5327</i>.</p>												
48	Types of Bills for FIs Table 2	<p>Effective 07/01/06: Add new row to Table 2: Facility Type: Hospital Inpatient Part B including Critical Access Hospitals (CAHs); Type of Bill: 12X; and Revenue Codes: 0403. See <i>MM4243 (2006) and/or CR 4243</i>. Revise 1st Note below Table 2 to: Effective April 1, 2005, the correct TOB for hospitals billing Medicare for diagnostic and screening mammographies is 13X. Payment for outpatient services of a CAH is subject to applicable Medicare Part B deductible and coinsurance amounts unless waived based on statute.</p>												
49	Type of Bills for FIs Table 2	<p>Revise 1st Note to: Effective April 1, 2005, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter, 052X, or 0900. See <i>Claims Processing Manual, Chapter 9, Sections 100, 110 & 120</i>.</p>												
49	Additional Billing Instructions for RHCs and FQHCs	<p>Effective 07/01/06: Change Professional Component, 2nd bullet, to read: "RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 to report the related visit." See <i>MM4210 (2006) and/or CR 4210</i>.</p>												
50	Reimbursement Information – General Information	<p>5th paragraph, change to: Reimbursement for CAD mammography codes 77051 and 77052 cannot be made if billed alone. They must be billed in conjunction with the primary service codes (Table 1). See <i>MM5327 (2006) and/or CR 5327</i>.</p>												
51	Types of Payments Received for Mammography Services Furnished by Facilities Table 3	<p>Replace Table 3 with the following table:</p> <table border="1"> <thead> <tr> <th>Provider of Service</th> <th>Form of Payment</th> </tr> </thead> <tbody> <tr> <td>CAH</td> <td>Reasonable Cost Basis (See following options)</td> </tr> <tr> <td>FQHC</td> <td>All-inclusive rate for the professional component (codes 77055, 77056, and 77057)</td> </tr> <tr> <td>Hospital Outpatient Department</td> <td>Medicare Physician Fee Schedule (MPFS)</td> </tr> <tr> <td>RHC</td> <td>All-inclusive rate for the professional component (codes 77055, 77056, and 77057)</td> </tr> <tr> <td>SNF</td> <td>MPFS</td> </tr> </tbody> </table> <p>See <i>MM5327 (2006) and/or CR 5327</i>.</p>	Provider of Service	Form of Payment	CAH	Reasonable Cost Basis (See following options)	FQHC	All-inclusive rate for the professional component (codes 77055, 77056, and 77057)	Hospital Outpatient Department	Medicare Physician Fee Schedule (MPFS)	RHC	All-inclusive rate for the professional component (codes 77055, 77056, and 77057)	SNF	MPFS
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RHC	All-inclusive rate for the professional component (codes 77055, 77056, and 77057)													
SNF	MPFS													
51	CAH Payment under the Optional Method (All-Inclusive)	<p>2nd paragraph, change to: CAHs that have elected the optional method of reimbursement bill the FI with TOB 85X, revenue code 0403, and HCPCS code 77057. These facilities also include the professional component on a separate line, repeating revenue code 0403 and HCPCS code 77057, and adding modifier -26 to designate the professional component. See <i>MM5327 (2006) and/or CR 5327</i>.</p>												
52	Reasons for Claim Denial	<p>Revise 3rd bullet to: The beneficiary received a screening mammogram from a non-FDA or a non-State/MQSA-certified mammography provider.</p>												

Screening Pap Tests

Page Number	Section Title and/or Number	Description of Change																		
55	Risk Factors	Delete headings <u>Cervical Cancer High Risk Factors</u> and <u>Vaginal Cancer High Risk Factors</u>																		
58	Diagnosis Requirements	Add Pap test diagnosis code V72.31 to Table 4. See MM3659 (2005) and/or CR 3659.																		
59	Types of Bills for Fls Table 5	<p>Delete from statement above Table 5: "[and two additional bill types in limited situations with Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)]"</p> <p>Replace Table 5 in its entirety with the following table:</p> <table border="1"> <thead> <tr> <th>Facility Type</th> <th>Type of Bill</th> <th>Revenue Codes</th> </tr> </thead> <tbody> <tr> <td>Hospital Inpatient Part B including Critical Access Hospitals (CAHs)</td> <td>12X</td> <td rowspan="2">0311</td> </tr> <tr> <td>Hospital Outpatient</td> <td>13X</td> </tr> <tr> <td>Hospital Non-patient Laboratory Specimens including CAHs</td> <td>14X</td> <td>030X, 031X</td> </tr> <tr> <td>Skilled Nursing Facility (SNF) Inpatient Part B</td> <td>22X</td> <td rowspan="3">0311</td> </tr> <tr> <td>SNF Outpatient</td> <td>23X</td> </tr> <tr> <td>CAH</td> <td>85X</td> </tr> </tbody> </table> <p>See MM3835 (2005) and/or CR 3835 (regarding TOB 14X). Effective 07/01/06: See MM4243 (2006) and/or CR 4243 (regarding TOB 12X). Delete 1st Note below Table 5.</p>	Facility Type	Type of Bill	Revenue Codes	Hospital Inpatient Part B including Critical Access Hospitals (CAHs)	12X	0311	Hospital Outpatient	13X	Hospital Non-patient Laboratory Specimens including CAHs	14X	030X, 031X	Skilled Nursing Facility (SNF) Inpatient Part B	22X	0311	SNF Outpatient	23X	CAH	85X
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CAH	85X																			
60	Additional Billing Instructions for RHCs and FQHCs Coding Tip Text Box Billing Requirements for the Professional Component for RHCs and FQHCs	<p>Revise paragraph to read: "There are specific billing and coding requirements for the technical component when a pap smear is furnished in a RHC or FQHC. The technical component is defined as services rendered outside the scope of the physician's interpretation of the results of an examination." Add to end of 2nd sentence: "...except for RHCs and FQHCs."</p> <p>Delete this section.</p>																		

Pelvic Screening Examination

Page Number	Section Title and/or Number	Description of Change																			
Throughout chapter	Throughout chapter	Change chapter tab/title and text throughout chapter to read "Screening Pelvic Examination".																			
65	Risk Factors	Delete headings <u>Cervical Cancer High Risk Factors</u> and <u>Vaginal Cancer High Risk Factors</u>																			
67	Diagnosis Requirements	Add pelvic examination diagnosis code V72.31 to Table 2. See MM3659 (2005) and/or CR 3659.																			
68	Types of Bills for Fls Table 3	<p>Replace Table 3 in its entirety with the following table:</p> <table border="1"> <thead> <tr> <th>Facility Type</th> <th>Type Of Bill</th> <th>Revenue Codes</th> </tr> </thead> <tbody> <tr> <td>Hospital Inpatient Part B including Critical Access Hospitals (CAHs)</td> <td>12X</td> <td rowspan="4">0770</td> </tr> <tr> <td>Hospital Outpatient</td> <td>13X</td> </tr> <tr> <td>Skilled Nursing Facility (SNF) Inpatient Part B</td> <td>22X</td> </tr> <tr> <td>SNF Outpatient</td> <td>23X</td> </tr> <tr> <td>CAH*</td> <td>85X</td> <td rowspan="3">052X</td> </tr> <tr> <td>Rural Health Clinic (RHC)</td> <td>71X</td> </tr> <tr> <td>Federally Qualified Health Center (FQHC)</td> <td>73X</td> </tr> </tbody> </table> <p>Effective 07/01/06: See MM4243 (2006) and/or CR 4243 (regarding TOB 12X).</p>	Facility Type	Type Of Bill	Revenue Codes	Hospital Inpatient Part B including Critical Access Hospitals (CAHs)	12X	0770	Hospital Outpatient	13X	Skilled Nursing Facility (SNF) Inpatient Part B	22X	SNF Outpatient	23X	CAH*	85X	052X	Rural Health Clinic (RHC)	71X	Federally Qualified Health Center (FQHC)	73X
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Pelvic Screening Examination (Cont.)

Page Number	Section Title and/or Number	Description of Change
69	Billing Requirements for the Professional Component for RHCs and FQHCs	Effective 07/01/06: Add to 2 nd paragraph: RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520. See <i>MM4210 (2006) and/or CR 4210.</i>

Colorectal Cancer Screening

Page Number	Section Title and/or Number	Description of Change
75	Overview	Add the following new paragraph after 3 rd paragraph: New for 2007 As a result of the Deficit Reduction Act (DRA) of 2005, effective for services provided on or after January 1, 2007, the colorectal cancer screening benefit is exempt from the Medicare Part B deductible. See <i>MM5127 (2006) and/or CR 5127.</i>
76	Coverage Information	1 st paragraph, change to: All Medicare beneficiaries age 50 and older are covered. However, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema rendered in place of that screening colonoscopy. The covered tests/procedures are: Paragraph after bullets, revise 3 rd sentence to: For all other procedures, the coinsurance or copayment applies; however, there is no deductible. See <i>MM5127 (2006) and/or CR 5127.</i>
77	Screening Flexible Sigmoidoscopy	Revise 1 st sentence to: Medicare provides for coverage of a screening flexible sigmoidoscopy for all beneficiaries without regard to age. A doctor of medicine or osteopathy must order this screening.
77	Screening Colonoscopy	Text Box Revisions: Change Title to: "Who can perform a screening colonoscopy?" Change text to: Screening colonoscopies must be performed by a doctor of medicine or osteopathy.
79	Procedure Codes and Descriptors Table 1	Delete HCPCS Code G0107 and replace with CPT code 82270. See <i>MM5292 (2006) and/or CR 5292.</i>
79	Procedure Codes and Descriptors Table 1	Add the following Note below Table 1: Effective January 1, 2007, CPT code 82270 replaces HCPCS code G0107 for screening fecal occult blood tests. See <i>MM5292 (2006) and/or CR 5292.</i>
79	Non-Covered Colorectal Screening Services	Revise paragraph to: Medicare covers colorectal barium enemas only in lieu of covered screening flexible sigmoidoscopies (G0104) or covered screening colonoscopies (G0105). However, there may be instances when the beneficiary has elected to receive the barium enema for colorectal screening other than specifically for these purposes. In such situations, the beneficiary may require a formal denial of the service from Medicare in order to bill a supplemental insurer who may cover the service. These noncovered barium enemas are to be identified by G0122 (colorectal cancer screening; barium enema). Code G0122 should not be used for covered barium enema services, that is, those rendered in place of the covered screening colonoscopy or covered flexible sigmoidoscopy. The beneficiary is liable for payment of the noncovered barium enema.
81	Types of Bills for FIs Table 5	Add row to Table 5: Facility Type: Hospital Non-patient Laboratory Specimens including Critical Access Hospitals (CAHs); Type of Bill: 14X**; Revenue Codes: 030X, 031X (HCPCS G0107 and G0328 only). See <i>MM3835 (2005) and/or CR 3835.</i> Add a Note after table 5 explaining the double asterisk after TOB 14X that reads: "All hospitals submitting claims containing CPT code 82270 and HCPCS code G0328 for non-patient laboratory specimens should use TOB 14X." See <i>MM4272 (2006) and/or CR 4272 and MM5292 (2006) and/or CR 5292.</i>

Colorectal Cancer Screening (Cont.)

Page Number	Section Title and/or Number	Description of Change
81	Types of Bills for FIs Table 6	Delete HCPCS Code G0107 and replace with CPT code 82270. See <i>MM5292 (2006) and/or CR 5292</i> . Delete the following text in Table 6: "Each FI may choose to accept other bill types for the colorectal cancer screening procedures. If another bill type is used other than 13X, 83X, or 85X, contact the local Medicare FI to determine if the particular bill type is allowed."
82	Special Billing Instructions for Skilled Nursing Facilities (SNFs) Table 7	Delete HCPCS Code G0107 and replace with CPT code 82270. See <i>MM5292 (2006) and/or CR 5292</i> . Add the following new paragraph below Table 7: There is no Medicare Part B deductible or coinsurance/copayment for the FOBT. For all other colorectal screening tests, there is no deductible. Coinsurance or copayments apply. See <i>MM5127 (2006) and/or CR 5127</i> .
82	Payment by Carriers of Interrupted and Completed Colonoscopies	Revised the 1 st sentence to: When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay the physician for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. See <i>Claims Processing Manual, Chapter 18, Section 60.2</i> .
83	Reimbursement of Claims by Fiscal Intermediaries (FIs) Table 8	Delete HCPCS Code G0107 and replace with CPT code 82270. See <i>MM5292 (2006) and/or CR 5292</i> .

Prostate Cancer Screening

Page Number	Section Title and/or Number	Description of Change																														
92	Types of Bills for FIs	Replace Table 2 in its entirety with the following table. See <i>MM3835 (2005) and/or CR 3835</i> (regarding TOB 14X). <table border="1" data-bbox="699 989 1490 1560"> <thead> <tr> <th>Facility Type</th> <th>Type of Bill</th> <th>Revenue Codes</th> </tr> </thead> <tbody> <tr> <td>Hospital Inpatient Part B including Critical Access Hospitals (CAHs)</td> <td>12X</td> <td>0770 - DRE 030X - PSA</td> </tr> <tr> <td>Hospital Outpatient</td> <td>13X</td> <td></td> </tr> <tr> <td>Hospital Non-patient Laboratory Specimens including CAHs</td> <td>14X</td> <td>030X-PSA</td> </tr> <tr> <td>Skilled Nursing Facility (SNF) Inpatient Part B</td> <td>22X</td> <td>0770 - DRE 030X - PSA</td> </tr> <tr> <td>SNF Outpatient</td> <td>23X</td> <td></td> </tr> <tr> <td>Rural Health Clinic (RHC)</td> <td>71X</td> <td>052X - DRE only</td> </tr> <tr> <td>Federally Qualified Health Center (FQHC)</td> <td>73X</td> <td>052X - DRE only</td> </tr> <tr> <td>Comprehensive Outpatient Rehabilitation Facility (CORF)</td> <td>75X</td> <td>0770 - DRE 030X - PSA</td> </tr> <tr> <td>CAH</td> <td>85X</td> <td></td> </tr> </tbody> </table>	Facility Type	Type of Bill	Revenue Codes	Hospital Inpatient Part B including Critical Access Hospitals (CAHs)	12X	0770 - DRE 030X - PSA	Hospital Outpatient	13X		Hospital Non-patient Laboratory Specimens including CAHs	14X	030X-PSA	Skilled Nursing Facility (SNF) Inpatient Part B	22X	0770 - DRE 030X - PSA	SNF Outpatient	23X		Rural Health Clinic (RHC)	71X	052X - DRE only	Federally Qualified Health Center (FQHC)	73X	052X - DRE only	Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0770 - DRE 030X - PSA	CAH	85X	
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92	Types of Bills for FIs Table 2	Revise 2 nd Note under Table 2 to: Effective April 1, 2005, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter, 052X, or 0900. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520. See <i>Claims Processing Manual, Chapter 9, Sections 100, 110 & 120</i> .																														

Prostate Cancer Screening (Cont.)

Page Number	Section Title and/or Number	Description of Change
93	Reimbursement of Claims by Fiscal Intermediaries (FIs) Table 3	Revise 2 nd column, 1 st line of Table 3 to: Outpatient Prospective Payment System (OPPS) for code G0102, Clinical Lab Fee Schedule for code G0103. Add the following Note under Table 3: * Effective April 1 st , 2006, the type of bill 14X is for non-patient laboratory specimens only.
93	Reasons for Claim Denial	Revise 1 st bullet to: The beneficiary is not at least age 50. (Coverage begins the day after the beneficiary's 50 th birthday.)

Influenza, Pneumococcal, and Hepatitis B Vaccinations

Page Number	Section Title and/or Number	Description of Change
97	Risk Factors for Influenza	Revise 2 nd bullet to: Children aged 6 - 59 months Revise 3 rd bullet to: Pregnant women
99	Procedure Codes and Descriptors Table 1 Diagnosis Requirements	Add HCPCS/CPT Code 90660 – Influenza virus vaccine, live, for intranasal use Add to the end of paragraph: "Effective October 1, 2006, providers may report diagnosis code V06.6 on claims for influenza virus and/or Pneumococcal Polysaccharide Vaccines when the purpose of the visit was to receive both vaccines."
100	Billing and Coding Requirements When Submitting to Carriers Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)	Add HCPCS code 90660 to the list of codes in the section. Add HCPCS code 90660 to the list of codes in the section.
101	Types of Bills for FIs Table 2	Change 1st row of table, under Facility Type, from "Hospital Inpatient Part B" to "Hospital Inpatient Part B including Critical Access Hospitals (CAHs)".
104	Reimbursement of Claims by Fiscal Intermediaries (FIs)	Effective 07/01/06: Change sentence to read: "...except CORFs, Indian Health Service (IHS) hospitals, IHS CAHs, and independent RDFs, which are paid based on 95% of the Average Wholesale Price." See <i>MM4240 (2006) and/or CR 4240</i> .
105	Coverage Information	1st paragraph, 2nd sentence: Change to read: "...once in a lifetime generally for all Medicare beneficiaries."
107	Diagnosis Requirements	Add to the end of the paragraph: "Effective October 1, 2006, providers may report diagnosis code V06.6 on claims for PPV and/or influenza virus vaccines when the purpose of the visit was to receive both vaccines."
109	Types of Bills for FIs Table 4	Change 1st row of table, under Facility Type, from "Hospital Inpatient Part B" to "Hospital Inpatient Part B including Critical Access Hospitals (CAHs)".
111	Reimbursement of Claims by Fiscal Intermediaries (FIs)	Effective 07/01/06: Change sentence to read: "...except CORFs, Indian Health Service (IHS) hospitals, IHS CAHs, and independent RDFs, which are paid based on 95% of the Average Wholesale Price." See <i>MM4240 (2006) and/or CR 4240</i> .
113	Procedure Codes and Descriptors	Effective 07/01/06: Add to Table 5: <ul style="list-style-type: none"> ◆ Add "(for other than OPPS hospitals)" to HCPCS/CPT Code G0010 – Administration of Hepatitis B vaccine ◆ Insert an asterisk to G0010; put the following note under Table 5: ""Note: For claims with dates of service prior to January 1, 2006, OPPS and non-OPPS hospitals report G0010 for Hepatitis B vaccine administration. For claims with dates of service of January 1, 2006 and later, OPPS hospitals report 90471 or 90472 for Hepatitis B vaccine administration as appropriate in place of G0010." ◆ Add HCPCS/CPT Code 90471* – Immunization administration (for OPPS hospitals billing for the Hepatitis B vaccine administration) ◆ Add HCPCS/CPT Code 90472* – Each additional vaccine (for OPPS hospitals billing for the Hepatitis B vaccine administration) See <i>MM4240 (2006) and/or CR 4240</i> .

Influenza, Pneumococcal, and Hepatitis B Vaccinations (Cont.)

Page Number	Section Title and/or Number	Description of Change
115	Types of Bills for Fls Special Billing Information	Change 1 st row, Facility Type , from "Hospital Inpatient Part B" to "Hospital Inpatient Part B including Critical Access Hospitals (CAHs)". Add double asterisks to Type of Bill codes 71X and 73X. Add a Note: "***Note: While Hepatitis B is a covered vaccine that is given by RHCs and FQHCs, it does not constitute a billable visit." Effective 07/01/06: Add: RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520. See <i>MM4210 (2006) and/or CR 4210.</i>
116	Reimbursement of Claims by Fiscal Intermediaries (Fls)	Effective 07/01/06: Change sentence to read: "...except CORFs, Indian Health Service (IHS) hospitals, IHS CAHs, and independent RDFs, which are paid based on 95% of the Average Wholesale Price". See <i>MM4240 (2006) and/or CR 4240.</i>
117	What is a "Mass Immunizer"?	Revised Note under 1 st paragraph to: Roster billing is only allowed for influenza and PPV vaccinations. HBV claims may not be submitted on roster bills.
122	To Participate in the Centralized Billing Program	Add the following bullet to list: Names of other entities operating under the corporation's application.

Bone Mass Measurements

Page Number	Section Title and/or Number	Description of Change																
125	Methods of Bone Mass Measurements	Revise the 1 st sentence to: Bone density is usually studied by using one of the various available diagnostic measurements that have been recognized by the FDA for that purpose.																
125	Standardizing Bone Density Studies	Revise the 1 st sentence to: To ensure accurate measurement and consistent test results, bone density studies should generally be performed for periodic follow-up tests on the same suitable precise instrument, and results should be obtained from the same scanner when comparing a patient to a control population.																
126	Coverage Information	Revise 3rd bullet to: An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy 5.0 mg of prednisone, or greater, per day, for more than three months. See <i>MM5443 (2006) and/or CR 5443.</i>																
128	Procedure Codes and Descriptors Table 1	Effective 01/01/2007: Replace Table 1 with the following Table: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">HCPCS/CPT Codes</th> <th style="text-align: center;">HCPCS/CPT Code Descriptors</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">G0130</td> <td>Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)</td> </tr> <tr> <td style="text-align: center;">77078</td> <td>Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)</td> </tr> <tr> <td style="text-align: center;">77079</td> <td>Computed tomography, bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)</td> </tr> <tr> <td style="text-align: center;">77080</td> <td>Dual energy x-ray absorptiometry (DXA) bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)</td> </tr> <tr> <td style="text-align: center;">77081</td> <td>Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)</td> </tr> <tr> <td style="text-align: center;">77083</td> <td>Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), one or more sites</td> </tr> <tr> <td style="text-align: center;">76977</td> <td>Ultrasound bone density measurement and interpretation, peripheral site(s), any method</td> </tr> </tbody> </table> <p><i>See MM5443 (2006) and/or CR 5443.</i></p>	HCPCS/CPT Codes	HCPCS/CPT Code Descriptors	G0130	Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	77078	Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)	77079	Computed tomography, bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	77080	Dual energy x-ray absorptiometry (DXA) bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)	77081	Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	77083	Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), one or more sites	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
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Bone Mass Measurements (Cont.)

Page Number	Section Title and/or Number	Description of Change																					
128	<p>Procedure Codes and Descriptors</p> <p>Diagnosis Requirements</p>	<p>Revise 1st paragraph to: Bone mass measurements are performed to establish the diagnosis of osteoporosis and to assess the individual's risk for subsequent fracture. Bone densitometry includes the use of single energy X-ray absorptiometry (SEXA), dual energy X-ray absorptiometry (DEXA), quantitative computed tomography (QCT), and bone ultrasound densitometry (BUD).</p> <p>Add the following second Note under Table 1: Medicare does not pay for Single Photon Absorptiometry (CPT code 78350). This procedure is not reported under CPT code 77080 or 77081.</p> <p>Revise this section to: Medicare will not pay for procedure codes 77078, 77079, 77081, 77083, 76977 and G0131 when billed with the following ICD-9-CM diagnosis codes: 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0.</p> <p>Medicare will pay for procedure code 77080 when billed with the following ICD-9-CM diagnosis codes 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 or any of the other valid ICD-9-CM diagnosis codes that are recognized by Medicare Contractors as appropriate for bone mass measurements. For further guidance, contact your Medicare Contractor. See MM5443 (2006) and/or CR 5443.</p>																					
129	Types of Bills for FIs Table 2	<p>Replace Table 2 in its entirety with the following table:</p> <table border="1"> <thead> <tr> <th>Facility Type</th> <th>Type of Bill</th> <th>Revenue Code</th> </tr> </thead> <tbody> <tr> <td>Hospital Inpatient Part B including CAHs</td> <td>12X</td> <td rowspan="4">0320</td> </tr> <tr> <td>Hospital Outpatient</td> <td>13X</td> </tr> <tr> <td>Skilled Nursing Facility (SNF) Inpatient Part B</td> <td>22X</td> </tr> <tr> <td>SNF Outpatient</td> <td>23X</td> </tr> <tr> <td>Rural Health Clinic (RHC)</td> <td>71X</td> <td>052X</td> </tr> <tr> <td>Federally Qualified Health Center (FQHC)</td> <td>73X</td> <td>052X</td> </tr> <tr> <td>CAH*</td> <td>85X</td> <td>0320</td> </tr> </tbody> </table> <p>See MM3835 (2005) and/or CR 3835 (regarding TOB 14X).</p>	Facility Type	Type of Bill	Revenue Code	Hospital Inpatient Part B including CAHs	12X	0320	Hospital Outpatient	13X	Skilled Nursing Facility (SNF) Inpatient Part B	22X	SNF Outpatient	23X	Rural Health Clinic (RHC)	71X	052X	Federally Qualified Health Center (FQHC)	73X	052X	CAH*	85X	0320
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130	Reimbursement Information – General Information	<p>Revise 1st sentence to: The Medicare Part B deductible and coinsurance or copayment apply, except for FQHC services. FQHC services are not subject to a deductible.</p>																					

Glaucoma Screening

Page Number	Section Title and/or Number	Description of Change
135	Risk Factors	<p>Insert 4th bullet: Hispanic-Americans 65 and over (new addition to benefit in 2006). See MM4365 (2006) and/or CR 4365.</p>
136	Risk Factors	<p>1st paragraph, 1st sentence: Change to read "It is of special importance for African-Americans, Hispanic-Americans, and those with diabetes and a family history of glaucoma to receive glaucoma screenings." See MM4365 (2006) and/or CR 4365.</p>

Glaucoma Screening (Cont.)

Page Number	Section Title and/or Number	Description of Change
138	Types of Bills for FIs Table 2	<p>Change Rural Health Clinic (RHC) Revenue Code to "Use bill type 71X and RHC revenue code 052X to report the related visit. FIs will only pay for the visit, 052X."</p> <p>Change Federally Qualified Health Center (FQHC) Revenue Code to "Use bill type 73X and FQHC revenue code 052X to report the related visit."</p> <p>Revise 2nd Note to: Effective April 1, 2005, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter, 052X, or 0900. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520. See <i>Claims Processing Manual, Chapter 9, Sections 100, 110 & 120.</i></p>