



Southeast Radiology Management

Management • Billing • Compliance • Audits

www.seradmgt.com

Coding & Coverage for US Screening for AAA

Medicare has created a new code to report an ultrasound examination used to screen for an abdominal aortic aneurysm.

G0389: Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening.



Effective for dates of service on and after January 1, 2007 Medicare will pay for a one-time ultrasound screening for AAA, for beneficiaries who meet the following criteria:

- *Receives a referral for such an ultrasound screening as a result of an initial preventive physical examination*
- Receives such ultrasound screening from a provider or supplier who is authorized to provide covered ultrasound diagnostic services.
- Has not been previously furnished such an ultrasound screening under the Medicare Program
- Is included in at least one of the following risk categories:
 1. Has a family history of abdominal aortic aneurysm;
 2. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime;
 3. Is a beneficiary, who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force (USPSTF) regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

To read the USPSTF recommendations go to:

http://www.guideline.gov/summary/summary.aspx?doc_id=6013&nbr=3960#s25

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

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

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

For additional information from CMS, go to:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5235.pdf>

Created by:

Stacie L. Buck, RHIA, CCS-P, LHRM, RCC

Vice President, Southeast Radiology Management