Medicare
Hospital Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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NEW/REVISED MATERIAL--*EFFECTIVE DATE*: *January 1, 2000*
IMPLEMENTATION DATE*: *October 1, 2000

Section 424, Prostate Cancer Screening Tests and Procedures, states that the revenue code 770 is to be used with HCPCS code G0102, digital rectal examination; and revenue code 30X is to be used with HCPCS code G0103, prostate specific antigen blood test.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

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CHAPTER IV
BILLING PROCEDURES

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Section

Uniform Billing

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Form HCFA-1450

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Billing in Medicare Secondary Payer Situations

424. PROSTATE CANCER SCREENING TESTS AND PROCEDURES

A. Coverage Requirements.--Section 4103 of the Balanced Budget Act of 1997 provides for coverage of certain prostate cancer screening tests subject to certain coverage, frequency, and payment limitations. Effective for services furnished on or after January 1, 2000, Medicare will cover prostate cancer screening tests/procedures for the early detection of prostate cancer. Coverage of prostate cancer screening tests includes the following procedures furnished to an individual for the early detection of prostate cancer:

- o Screening digital rectal examination.
- o Screening prostate specific antigen (PSA) blood test.

1. Screening digital rectal examinations are covered at a frequency of once every 12 months for men who have attained age 50 (i.e., starting at least one day after they have attained age 50), if at least 11 months have passed following the month in which the last Medicare-covered screening digital rectal examination was performed. Screening digital rectal examination means a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate. This screening must be performed by a doctor of medicine or osteopathy (as defined in §186l (r)(1) of the Act), or by a physician assistant, nurse practitioner, clinical nurse specialist, or by a certified nurse mid-wife (as defined in §1861(aa) and §1861(gg) of the Act), who is authorized under State law to perform the examination, fully knowledgeable about the beneficiary, and would be responsible for explaining the results of the examination to the beneficiary.

2. Screening PSA tests are covered at a frequency of once every 12 months for men who have attained age 50 (i.e., starting at least one day after they have attained age 50), if at least 11 months have passed following the month in which the last Medicare-covered screening prostate specific antigen test was performed. Screening PSA is a test that measures the level of prostate specific antigen in an individual's blood. This screening must be ordered by the beneficiary's physician or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife (the term "physician" is defined in §1861 (r)(1) of the Act to mean a doctor of medicine or osteopathy and the terms "physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife" are defined in §1861 (aa) and §1861 (gg) of the Act) who is fully knowledgeable about the beneficiary, and who would be responsible for explaining the results of the test to the beneficiary.

B. Billing Requirements.--Follow the general bill review instructions in §3604 of the Medicare Intermediary Manual, Part 3. The provider will bill on Form HCFA-1450 or electronic equivalent. The appropriate bill types are 12X, 13X, 14X, 22X, 23X, 71X, 73X, 75X, and 85X.

The following HCPCS and revenue codes should be used for prostate screening:

- o G0102 - Use revenue code 770, prostate cancer screening; digital rectal examination.
- o G0l03 - Use revenue code 30x, prostate cancer screening; prostate specific antigen testing.

C. Payment Requirements Intermediaries.--

o G0102 - digital rectal examination - Deductible and coinsurance apply. Payment varies depending on the facility providing the service as follows:

12X = Outpatient Prospective Payment System
13X = Outpatient Prospective Payment System
14X = Outpatient Prospective Payment System
22X = Reasonable Cost
23X = Reasonable Cost
71X = All Inclusive Rate
73X = All Inclusive Rate
75X = Medicare Physician Fee Schedule
85X = Cost (Payment should be consistent with amounts you pay for code 84153 or code 86316.)

o G0103 - antigen test - pay under the clinical diagnostic lab fee schedule. Use CPT code 99211 as a guide. Deductible and coinsurance apply.

D. Calculating Frequency.--To determine the 11 month period, start the count beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received a screening prostate specific antigen test in January 2000. Start your count beginning February 2000. The beneficiary is eligible to receive another screening prostate specific antigen test in January 2001 (the month after 11 months have passed).

E. Common Working File (CWF) Edits.--Beginning October 1, 2000, CWF edits will be implemented for dates of service January 1, 2000, and later, for prostate cancer screening tests and procedures. CWF will edit for:

1. Age
2. Frequency
3. Sex
4. Valid HCPCS code

F. Medicare Summary Notice (MSN) and Explanation of Your Medicare Benefits (EOMB) Messages.--If a claim for screening prostate specific antigen test or a screening digital rectal examination is being denied because of the age of the beneficiary, the MSN or EOMB will have the following message:

"This service is not covered for beneficiaries under 50 years of age." (MSN Message 18-13, EOMB Message 18-22)

If the claim for screening prostate specific antigen test or screening digital rectal examination is being denied because the time period between the same test or procedure has not passed, the MSN or EOMB will have the following message:

"Service is being denied because it has not been 12 months since your last test/procedure) of this kind." (MSN Message 18-14, EOMB Message 18-23)

Este servicio está siendo denegado ya que no han transcurrido (12, 24, 48) meses desde el último (examen/procedimiento) de esta clase.

G. Remittance Advice Notices.--If the claim for a screening prostate antigen test or screening digital rectal examination is being denied because the patient is under 50 years of age, use existing American National Standard Institute (ANSI) X12-835 claim adjustment reason code 6 "the procedure code is inconsistent with the patient's age", at the line level along with line level remark code M140 "Service is not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday."

If the claim for a screening prostate specific antigen test or screening digital rectal examination is being denied because the time period between the test/procedure has not passed, the FI will use existing ANSI X12-835 claim adjustment reason code 119 "Benefit maximum for this time period has been reached" at the line level.