CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 26 **Date: NOVEMBER 4, 2003**

CHANGE REQUEST 2688

I. SUMMARY OF CHANGES: New sections are being added to the outpatient and inpatient chapters of this manual because of new coverage of lung volume reduction surgery (LVRS). **(Hyperlink inserted for Chapter 3, §100.7 and Chapter 4, §310.)**

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004
***IMPLEMENTATION DATE: January 5, 2004**
****M+C IMPLEMENTATION DATE: April 5, 2004**
(Corresponding one-time notification contains billing instructions for M+C plan providers.)**

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.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED –

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/Table of Contents
N	3/100.7-Lung Volume Reduction Surgery
R	4/Table of Contents
N	4/310-Lung Volume Reduction Surgery

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
X	**One-Time Notification**

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev. 3, 11-04-03)

100.7 – Lung Volume Reduction Surgery

(Rev. 3, 11-04-03)

Lung Volume Reduction Surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for discharges on or after January 1, 2004, Medicare will cover LVRS under certain conditions as described in §240 of Pub. 100-03, "National Coverage Determinations".

The Medicare Code Editor (MCE) creates a Limited Coverage edit for procedure code 32.22. This procedure code has limited coverage due to the stringent conditions that must be met by hospitals. Where this procedure code is identified by MCE, the FI shall determine if coverage criteria is met and override the MCE if appropriate.

The LVRS can only be performed in the facilities listed on the following Web site:
www.cms.hhs.gov/coverage/lvrsfacility.pdf

Medicare previously only covered LVRS as part of the National Emphysema Treatment Trial (NETT). The study is limited to 18 hospitals, and patients are randomized into two arms, either medical management and LVRS or medical management. The study is conducted by The National Heart, Lung, and Blood Institute of the National Institutes of Health and coordinated by Johns Hopkins University (JHU). Claims for patients in the NETT are identified by the presence of Condition Code EY. The JHU instructs hospitals of the correct billing procedures for billing claims under the NETT. Claims processing procedures in place for the NETT remain the same.

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev. 3, 11-04-03)

310 - Lung Volume Reduction Surgery

(Rev. 3, 11-04-03)

Lung Volume Reduction Surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for 'from' dates of service on or after January 1, 2004, Medicare will cover LVRS under certain conditions as described in §240 of the Pub. 100-03, "National Coverage Determinations".

LVRS can only be performed in the facilities listed on the following website:
www.cms.hhs.gov/coverage/lvrsfacility.pdf

LVRS is an inpatient procedure. However pre- and post- operative services are performed on an outpatient basis and must be performed at one of the facilities certified to do so. These procedures are paid under the Outpatient Prospective Payment System (OPPS), except for hospitals located in Maryland.

Medicare previously only covered LVRS as part of the National Emphysema Treatment Trial (NETT). The study is limited to 18 hospitals, and patients are randomized into two arms, either medical management and LVRS or medical management. The study is conducted by The National Heart, Lung, and Blood Institute of the National Institutes of Health and coordinated by Johns Hopkins University (JHU). Claims for patients in the NETT are identified by the presence of Condition Code EY. JHU instructs hospitals of the correct billing procedures for billing claims under the NETT. Claims processing procedures in place for the NETT remain the same.

One-Time Notification

Pub. 100-4	Transmittal: 26	Date: November 4, 2003	Change Request 2688

SUBJECT: Claims Processing Instructions for New Coverage of Lung Volume Reduction Surgery (LVRS)

I. GENERAL INFORMATION

A. Background: Lung Volume Reduction Surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for discharges on or after January 1, 2004 (inpatient claims) and for 'from' dates of service on or after January 1, 2004 (outpatient claims), Medicare will cover LVRS under certain conditions as described in §240 of Pub. 100-03, National Coverage Determinations (NCD).

NOTE: This new coverage of LVRS is separate from claims processing instructions currently in place for the National Emphysema Treatment Trial (NETT). There are no changes to billing in the NETT.

B. Policy: National Coverage Determinations

C. Provider Education: Intermediaries shall inform affected providers by posting either a summary or relevant portions of this document on their Web site within 2 weeks of the date of this transmittal. Also, intermediaries shall publish this same information in their next regularly scheduled bulletin. If you have a listserv that targets affected providers, you shall use it to notify subscribers that updated information about coverage of LVRS is available on your Web site.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
2688.1	Medicare fiscal intermediaries (FIs) shall pay fee-for-service for inpatient hospital claims that contain the condition code 78 for risk M+C beneficiaries for discharges on or after January 1, 2004, with ICD-9-CM procedure code 32.22.	SSM
2688.1.1	FIs shall pay fee-for-service for outpatient hospital claims that contain the condition code 78 for risk M+C beneficiaries for 'from' dates of service on or after January 1, 2004, with the following HCPCS codes: G0302	SSM

	G0303 G0304 G0305	
2688.2	Until systems changes can be made, contractors shall hold claims for risk M+C beneficiaries that fall under the new coverage with condition code 78 for dates of service January 1, 2004, through March 31, 2004. (See requirements 1 and 1.1 for specific codes.)	SSM/FIs
2688.3	Contractors shall release claims for risk M+C beneficiaries for payment, including any applicable interest, on or after April 5, 2004. However, claims may be released earlier if system changes are in place.	SSM/FIs
2688.3.1	FIs shall enter condition code 15 when releasing held claims for payment.	SSM/FIs
2688.4	Contractors shall not apply Part A or Part B deductible to inpatient and outpatient claims with condition code 78 for M+C beneficiaries. (See requirements 1 and 1.1 for specific codes).	SSM/FIs
2688.5	Contractors shall apply applicable coinsurance for risk M+C beneficiaries who receive LVRS.	SSM/FIs
2688.6	Contractors shall publish provider education language on their Web sites as soon as possible, but no later than 2 weeks from the issuance date of this instruction.	FIs
2688.6.1	Contractors shall publish provider education in their next regularly scheduled bulletin.	FIs
2688.6.2	Contractors who have a listserv that targets the affected provider communities shall use their listservs to notify subscribers that updated information about claims processing for LVRS appears on the contractor's Web site.	FIs
2688.6.3	Contractors shall educate providers that only claims for patients with indications that are effective for coverage beginning January 1, 2004, should include condition code 78. Claims for non-risk managed care beneficiaries with existing covered indications should NOT be billed with condition code 78, as they are currently included in the capitated rates.	FIs

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
2688.1	TOB 11X.
2688.1.1	TOB 13X.

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
2688.4	Shared systems should not create any front-end edits for the requirements pertaining to claims for M+C beneficiaries. Shared systems should only react to claims rejected by CWF that contain condition code 78.
Background (All 13X claims for LVRS)	FIs shall create a Medical Policy Edit or other appropriate mechanism for the purposes of verifying that G0302 – G0305 is provided in a facility certified to perform LVRS effective for 'from' dates of service on or after January 1, 2004.
Background (All 13X claims for LVRS)	The facilities certified to perform services related to LVRS are paid under the Outpatient Prospective Payment System (OPPS), except for hospitals in Maryland.
Background (All 11X claims for LVRS)	FI shall suspend claims that receive the Medicare Code Editor (MCE) limited coverage edit for ICD-9-CM procedure code 32.22 and override if coverage conditions are met for discharges on or after January 1, 2004.
Background (All 11X claims for LVRS)	The facilities certified to perform LVRS are paid under the Inpatient Prospective Payment System, except for hospitals located in Maryland.

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: January 1, 2004 **Implementation Date: January 5, 2004 (fee-for-service claims)** **April 5, 2004 (claims for risk M+C beneficiaries)** **Pre-Implementation Contact(s): Sarah Shirey at Sshirey@cms.hhs.gov** **Post-Implementation Contact(s): regional office**	**These instructions should be implemented within your current operating budget.**