Medicare
Carriers Manual
Part 3 - Claims Process

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

Transmittal 1676 **Date: SEPTEMBER 14, 2000**

CHANGE REQUEST 1252

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter IV	4-3 - 4-4.4 (6 pp.)	4-3- 4-4.4 (6 pp.)
4182.3 - 4200	4-51 - 4-57 (7 pp.)	4-51 - 4-55 (5 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE*: January 1, 2001
***IMPLEMENTATION DATE*: January 1, 2001**

Section 4182.3, HCPCS Codes and Payment Requirements, is changed to state that a beneficiary must be over 50 years of age (starting at least one day after the beneficiary has attained age 50) and to delete the reference to "attending" physician to make the instruction consistent with Final Regulations published in the ***Federal Register*** (64 CFR 59380).

Section 4182.4, Calculating the Frequency, is changed to give a more illustrative example.

Section 4182.5, CWF Edits, is changed to delete the reference to a January 1, 2000 effective date for CWF edits because of delay in the implementation of CWF edits.

Section 4182.6, Correct Coding Requirements, is added to be consistent with the applicable Correct Coding Initiative requirements.

Section 4182.7, Diagnosis Coding Requirements, is added to indicate the appropriate screening "V" code to be used when billing for prostate cancer screening tests or procedures.

Section 4182.8, Denial Messages, is added to indicate the appropriate reason and remark codes as well as the new MSN and EOMB messages to be used by carriers.

Carries must notify providers of these changes in their next regularly scheduled bulletin.

These instructions should be implemented within your current operating budget.

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

CHAPTER IV

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CHAPTER IV

Submission of Claims to Medigap Insurers

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4182. PROSTATE CANCER SCREENING TESTS AND PROCEDURES

The following sections summarize coverage requirements and detail claims processing procedures for prostate cancer screening tests and procedures.

4182.1 Coverage Summary.--Sections 1861(s)(2)(P) and 1861(oo) of the Social Security Act (as added by §4103 of the Balanced Budget Act of 1997), provide for coverage of certain prostate cancer screening tests and procedures 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 and procedures for the early detection of prostate cancer. Coverage currently consists of the following tests and procedures furnished to an individual for the early detection of prostate cancer:

A. Screening Digital Rectal Examination.--This test is a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate; and

B. Screening Prostate Specific Antigen (PSA) Blood Test.--This test detects the marker for adenocarcinoma of the prostate.

For more information regarding coverage of prostate cancer screening tests and procedures, refer to §50-55 of the Coverage Issues Manual.

4182.2 Requirements for Submitting Claims.--Submit claims for prostate cancer screening tests on Health Insurance Claim Form HCFA-1500 or electronic equivalent. Follow the general instructions in §2010, Purpose of Health Insurance Claim Form HCFA-1500, Medicare Carriers Manual, Part 4, Chapter 2.

4182.3 HCPCS Codes and Payment Requirements.--The following table lists coverable codes and services for prostate cancer screening tests and procedures. Pay for these services according to the appropriate fee schedule when all of the requirements noted are met.

HCPCS Code; Type of Service (TOS)	Description	Payment	
		Requirements	Methodology/ Fee Schedule
G0102; TOS=1	Prostate cancer screening; digital rectal examination	1. Performed on a male Medicare beneficiary over 50 years of age (i.e., for services starting at least one day after the beneficiary attained age 50). 2. Performed by one of the following, who is authorized under State law to perform the examination, is fully knowledgeable about the beneficiary, and is responsible for explaining the results of the examination to the beneficiary: a. Doctor of medicine or osteopathy b. Qualified physician assistant c. Qualified nurse practitioner d. Qualified clinical nurse specialist e. Qualified certified nurse midwife 3. Performed at a frequency no greater than once every 12 months (See §4182.4).	1. Refer to the physician's fee schedule. 2. Apply deductible and coinsurance. 3. Claims from physicians for these examinations where assignment was not taken are subject to the Medicare limiting charge. (See §7555). 4. Correct Coding Initiative requirements apply. See §4182.6

G0103; TOS=5	Prostate cancer screening; PSA test	1. Performed on a male Medicare beneficiary over 50 years of age (i.e., for services starting at least one day after the beneficiary attained age 50) 2. Ordered by one of the following, who is authorized under State law to perform the examination, is fully knowledgeable about the beneficiary, and is responsible for explaining the results of the examination to the beneficiary: a. Physician (doctor of medicine or osteopathy) b. Qualified physician assistant c. Qualified nurse practitioner d. Qualified clinical nurse specialist e. Qualified certified nurse midwife 3. Performed at a frequency no greater than once every 12 months. (See §4182.4.)	1. Refer to the clinical laboratory fee schedule; payment for this test is the same as for code "84153, PSA; total." 2. Do not apply deductible and coinsurance.

4182.4 Calculating the Frequency.--Once a beneficiary has received any (or all) of the covered prostate cancer screening test/procedures, he may receive another (or all) of such test/procedures after 11 full months have passed. To determine the 11-month period, start your count beginning with the month after the month in which any (or all) of the previous covered screening test/procedures was performed.

EXAMPLE: The beneficiary received a screening PSA test on February 25, 2000. Start your count beginning March 2000. The beneficiary is eligible to receive another screening PSA test on February 1, 2001 (the month after 11 months have passed.)

4182.5 CWF Edits.--CWF will edit prostate cancer screening tests and procedures for age, frequency, sex, and valid HCPCS code.

4182.6 Correct Coding Requirements.--Billing and payment for a Digital Rectal Exam (DRE) (G0102) is to be bundled into the payment for a covered E/M service (CPT codes 99201-99456 and 99499) when the two services are furnished to a patient on the same day. If the DRE is the only service or is provided as part of an otherwise noncovered service, HCPCS code G0102 would be payable separately if all other coverage requirements are met.

4182.7 Diagnosis Coding Requirements.--There are no specific diagnosis requirements for prostate screening tests and procedures. However, prostate cancer screening digital rectal examinations and screening Prostate Specific Anitigen (PSA) blood tests must be billed using screening ("V") code V76.44 (Special Screening for Malignant Neoplasms, Prostate).

4182.8 Denial Messages.--

A. Remittance Advice Notices.--If the claim for a screening prostate antigen test or screening digital rectal examination is being denied because the patient is not over 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 not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the patient's 50th birthday"

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

If the claim for a screening prostate antingen test or screening digital rectal examination is being denied due to the absence of diagnosis code V76.44 on the claim, use existing ANSI X-12-835 claim adjustment reason code 47, "This (these) diagnosis (es) is (are) not covered, missing, or invalid."

B. Medicare Summary Notice (MSN) and Explanation of Your Medicare Benefits (EOMB) Messages.--If the claim for a screening prostate specific antigen test or screening digital rectal examination is being denied because the patient is not over 50 years of age, the following new line (May 2000) MSN or EOMB message:

"This service is not covered until after the beneficiary's 50th birthday." (MSN Message 18.19, EOMB Message 18.27)

The Spanish version of this MSN or EOMB message should read:

"Este servicio no está cubierto hasta después de que el beneficiario cumpla 50 años."

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

"Service is being denied because it has not been [12/24/48] months since your last [test/procedure] of this kind." (MSN Message 18.14, EOMB Message 18.23)

The Spanish version of this MSN or EOMB message should read:

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

4183. STEM CELL TRANSPLANTATION

Stem cell transplantation is a process in which stem cells are harvested from either a patient's or donor's bone marrow or peripheral blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (HDCT) and/or radiotherapy used to treat various malignancies. Allogeneic stem cell transplant may also be used to restore function in recipients having an inherited or acquired deficiency or defect.

Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses. See Coverage Issues Manual, §35-30.1 for a complete description of covered and noncovered conditions.

4183.1 General.--

A. Allogeneic Stem Cell Transplantation.--Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor's stem cells is obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect.

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

B. Autologous Stem Cell Transplantation.--Autologous stem cell transplantations is a technique for restoring stem cells using the patient's own previously stored cells. Autologous stem cell transplants are covered for certain specified diagnoses for services rendered on or after April 28, 1989.

4183.2 HCPCS and Diagnosis Coding.--

A. Allogeneic Stem Cell Transplantation.--

1. Effective for services performed on or after August 1, 1978:

- For the treatment of leukemia or leukemia in remission, ICD-9-CM codes 204.00 through 208.91 are to be entered in block 21 of the Form HCFA-1500 and HCPCS code 38240 is to be entered in block 24 D of the Form HCFA-1500; or

- For the treatment of aplastic anemia, ICD-9-CM codes 284.0 through 284.9 are to be entered in block 21 of the Form HCFA-1500 and HCPCS code 38240 are to be entered in block 24 D of the Form HCFA-1500.

2. Effective for services performed on or after June 3, 1985:

o For the treatment of severe combined immunodeficiency disease, ICD-9-CM code 279.2 should be entered in block 21 of the Form HCFA-1500 and HCPCS code 38240 are to be entered in block 24 D of the Form HCFA-1500;

o For the treatment of Wiskott-Aldrich syndrome, ICD-9-CM code 279.12 is to be entered in block 21 of the Form HCFA-1500 and HCPCS code 38240 is to be entered in block 24 D of the Form HCFA-1500.

3. Effective for services performed on or after May 24, 1996:

o Allogeneic stem cell transplantation, HCPCS code 38240 is not covered as treatment for the diagnosis of multiple myeloma ICD-9-CM codes 203.00 or 203.01.

B. Autologous Stem Cell Transplantation.--Is covered under the following circumstances effective for services performed on or after April 28, 1989:

o For the treatment of patients with acute leukemia in remission who have a high probability of relapse and who have no human leucocyte antigens (HLA) matched, ICD-9-CM code 204.01 lymphoid; ICD-9-CM code 205.01 myeloid; ICD-9-CM code 206.01 monocytic; or ICD-9-CM code 207.01 acute erythremia and erythroleukemia; or ICD-9-CM code 208.01 unspecified cell type should be entered in block 21 of the Form HCFA-1500 and HCPCS code 38241 is to be entered in block 24 D of the Form HCFA-1500.

o For the treatment of resistant non-Hodgkin's lymphomas for those patients presenting with poor prognostic features following an initial response, ICD-9-CM codes 200.00 - 200.08, 200.10-200.18, 200.20-200.28, 200.80-200.88, 202.00-202.08, 202.80-202.88 or 202.90-202.98 should be entered in block 21 of the Form HCFA-1500 and HCPCS code 38241 is to be entered in block 24 D of the Form HCFA-1500.

o For the treatment of recurrent or refractory neuroblastoma, ICD-9-CM codes Neoplasm by site, malignant, the appropriate HCPCS code should be entered in block 21 of the Form HCFA-1500 and HCPCS code 38241 is to be entered in block 24 D of the Form HCFA-1500.

o For the treatment of advanced Hodgkin's disease for patients who have failed conventional therapy and have no HLA-matched donor, ICD-9-CM codes 201.00 - 201.98 are to be entered in block 21 of the Form HCFA-1500 and HCPCS code 38241 is to be entered in block 24 D of the Form HCFA-1500.

C. Autologous Stem Cell Transplantation.--Is covered under the following circumstances effective for services furnished on or after October 1, 2000:

o For the treatment of multiple myeloma (only for beneficiaries who are less than age 78, have Durie-Salmon stage II or III newly diagnosed or responsive multiple myeloma, and have adequate cardiac, renal, pulmonary and hepatic functioning), ICD- 9-CM code 203.00 or 238.6 is to be entered in block 21 of the Form HCFA-1500 and HCPCS code 38241 is to be entered in block 24 D of the Form HCFA-1500.

o For the treatment of recurrent or refractory neuroblastoma, appropriate code (see ICD-9-CM neoplasm by site, malignant) is to be entered in block 21 of the Form HCFA-1500 and HCPCS code 38241 is to be entered in block 24D of the Form HCFA-1500.

o For the treatment of primary amyloidosis, ICD-9-CM code 277.3, for beneficiaries under age 64, coverage is at the discretion of the carrier medical director.

4183.3 NonCovered Conditions.--Autologous stem cell transplantation is not covered for the following conditions:

o Acute leukemia not in remission (ICD-9-CM codes 204.00, 205.00, 206.00, 207.00 and 208.00);

o Chronic granulocytic leukemia (ICD-9-CM codes 205.10 and 205.11);

o Solid tumors (other than neuroblastoma) (ICD-9-CM codes 140.0 through 199.1); or

o Effective for services rendered on or after May 24, 1996 through September 30, 2000, multiple myeloma (ICD-9-CM code 203.00 and 203.01).

o Effective for services on or after 10/01/00, for Medicare beneficiaries age 64 or older, all forms of amyloidosis, primary and non-primary (ICD-9-CM code 277.3).

o Effective for services on or after 10/01/00, for Medicare beneficiaries under age 64, non-primary amyloidosis (ICD-9-CM code 277.3).

NOTE: Coverage for conditions other than those specifically designated as covered in §4183.2 or specifically designated as non-covered in this section will be at the discretion of the individual carrier.

4183.4 Edits.--Appropriate diagnosis to procedure code edits should be implemented for the covered conditions and services in §4183.2.

As the ICD-9-CM code 277.3 for amyloidosis does not differentiate between primary and non-primary, carriers should perform prepay reviews on all claims with a diagnosis of ICD-9-CM code 277.3 and a HCPCS procedure code of 38241 to determine whether payment is appropriate.

4183.5 Suggested MSN/EOMB and RA Messages.--The following messages may be generated as appropriate:

MSN - 15.4, The information provided does not support the need for this service or item;

EOMB - 15.9, The information we have in your case does not support the need for this service;

RA - B22, This claim/service is denied/reduced based on the diagnosis.

Provider-Based Physician Billing

4200. BILLING FOR PROVIDER-BASED PHYSICIAN SERVICES

Professional services of provider-based physicians furnished on or after January 1, 1992, are billed to you on the Form HCFA-1500. Based payment for provider-based physician services on the physician fee schedule applicable for the date of service.