Medicare
Carriers Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 1457

CRYOSURGERY OF THE PROSTATE GLAND: NEW CPT CODE

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4173.6 - 4174.5	4-45.1f17 - 4-45.1f19 (3 pp.)	4-45.1f17 - 4-45.1fl20 (4 pp.)

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

***IMPLEMENTATION DATE:* April 1, 2001**

Sections 4174.3 and 4174.4, regarding cryosurgery of the prostate gland, are revised to reflect the following new code for this procedure and its accompanying ultrasonic guidance:

CPT 55873 Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)

Section 4173.4, Payment and Coding Requirements, describes these requirements for CPT 55873.

Section 4174.4, Processing Claims to Ensure That Payment Conditions Are Met, describes the edits and procedures necessary to adjudicate and process these claims effectively.

PLEASE NOTE THE FOLLOWING ADDITIONAL PROCEDURES REQUIRED AS A RESULT OF THE NEW CODE:

Implement the edits described in Sections 4174.3 and 4174.4 by April 1, 2001.

As this new code includes not only the cryosurgical ablation procedure but also the ultrasonic guidance for interstitial cryosurgical probe placement, it will replace, effective January 1, 2001, the previous two HCPCS codes: G0160 and G0161. **Providers may continue to use G0160 and G0161 codes for claims you receive on or before March 31, 2001.**

For this code transition period, implement edits effective January 1, 2001, **for claims received from January 1, 2001, through March 31, 2001,** as follows:

1. Deny any claim for CPT code 55873 when a claim for either HCPCS code G0160 or G0161 has already been paid for the same beneficiary for the same date of service.

2. Deny any claim for HCPCS code G0160 when a claim for CPT code 55873 has already been paid for the same beneficiary for the same date of service.

3. Deny any claim for HCPCS code G0161 when a claim for CPT code 55873 has already been paid for the same beneficiary for the same date of service.

Previously established CWF edits ensure that each claim for G0161 is paid only when a claim has already been paid for G0160 for the same beneficiary for the same date of service.

Because the new code includes payment for both procedures, do not pay separately for the ultrasonic guidance when CPT code 55873 is used; in situations where one provider has provided the cryosurgical ablation and another has provided the ultrasonic guidance for the same beneficiary for the same date of service, the provider of the cryosurgical ablation must submit the claim, and the provider of the ultrasonic guidance seek compensation from the provider of the cryosurgical ablation.

Please inform providers of coding, payment, and claims submission requirements by posting that information on your web site as soon as possible and publishing it in your 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.

Modifier	Description
N	Negative;
E	Equivocal;
P	Positive, but not suggestive of, extensive ischemia or not suggestive of malignant single pulmonary nodule; and
S	Positive and suggestive of; extensive ischemia (greater than 20 percent of the left ventricle) or malignant single pulmonary nodule.

These modifiers may be used in any combination.

4173.6 Claims Processing Instructions for PET Scan Claims.--

A. FDA Approval.--PET scans are covered only when performed at a PET imaging center with a PET scanner that has been approved or cleared by the FDA. When submitting the claim, the provider is certifying this and must be able to produce a copy of this approval upon request. An official approval letter need not be submitted with the claim.

You may consider conducting a review on a post-payment basis to verify, based on a sample of PET scan claims, that the PET scan was performed at a center with a PET scanner which was approved or cleared for marketing.

B. EOMB and Remittance Messages.--Providers must indicate the results of the PET scan and the previous test using a two-digit modifier as specified in §4173.4. Deny assigned claims received prior to April 1, 1996 without such modifier, using the following EOMB message:

> "Your service was denied because information required to make payment was missing. We have asked your provider to resubmit a claim with the missing information so that it may be reprocessed." (Message 9.33)

Deny unassigned claims received prior to April 1, 1996, without the two-digit modifier using the following EOMB message:

> "Medicare cannot pay for this service because the claim is missing information/documentation. Please ask your provider to submit a new, complete claim to us." (Messages 9.8 and 9.15)

Claims received on or after April 1, 1996, without the two-digit modifier must be returned as unprocessable. (See §3005.)

Use the following remittance message for assigned claims:

> "The procedure code is inconsistent with the modifier used, or a required modifier is missing." (Reason Code 4)

Assigned claims for dates of service on or after January 1, 1998, without the proper documentation must be denied using the following EOMB message:

> “Your service was denied because information required to make payment was missing. We have asked your provider to resubmit a claim with the missing information so that it may be reprocessed.” (Message 9.33)

C. Type of Service.--The type of service for the PET scan codes in the "G" range is 4, Diagnostic Radiology.

4174. CRYOSURGERY OF THE PROSTATE GLAND

4174.1 Summary.--Cryosurgery of the prostate gland, also known as cryosurgical ablation of the prostate (CSAP), destroys prostate tissue by applying extremely cold temperatures in order to reduce the size of the prostate gland. For claims with dates of service on or after July 1, 1999, Medicare covers cryosurgery of the prostate gland only as primary treatment for patients with clinically localized prostate cancer, stages T1-T3. (For more information regarding coverage, refer to §35-96 of the Medicare Coverage Issues Manual.)

4174.2 Requirements for Submitting Claims.--Providers must submit claims for cryosurgery of the prostate gland and for the accompanying ultrasonic guidance 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 (MCM), Part 4, Chapter 2.

4174.3 Payment and Coding Requirements.-- Pay for cryosurgery of the prostate gland and for the accompanying ultrasonic guidance only for CPT code 55873 and only as required below.

CPT Code; TOS* Description	Payment		
	Requirements	ICD-9-CM Code Description	Methodology/ Fee Schedule
55873;TOS=2 Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement).	Pay for this service only as a primary treatment for patients with clinically localized prostate cancer, stages T1-T3.	185 Malignant neoplasm of prostate.	Refer to the Medicare physician fee schedule, including applicable quarterly database updates. This code has a 90-day global indicator.

*Type of service.

NOTE: Instruct providers of the cryosurgical ablations to submit the claims. When one provider has furnished the cryosurgical ablation and another the ultrasonic guidance, the provider of the ultrasonic guidance must seek compensation from the provider of the cryosurgical ablation. Do not pay separately for the ultrasonic guidance associated with this procedure.

4174.4 Processing Claims to Ensure That Payment Conditions Are Met.--

A. Implement Edits.—

1. General. --Implement edits to ensure that the payment requirements under §4174.3 are met.

2. CWF Rejections.--

a. Any claim for CPT code 55873 which indicates that the beneficiary was female.

b. Any claim for CPT code 55873 for which there is already a record of a paid claim for 55873 for the same beneficiary for the same date of service.

B. Ensure that Patients Meet Coverage Requirements.--To ensure that claims for cryosurgery of the prostate gland meet the requirements that the cryosurgery be performed only as a primary treatment for patients with clinically localized prostate cancer, stages T1-T3, implement one or both of the following procedures as you find appropriate:

1. Require that providers submit paper claims with the appropriate documentation attached. This choice would be appropriate if you anticipate a small volume of these claims; and/or

2. Conduct post-payment reviews as necessary.

C. Send Provider Remittance Messages and MSNs/EOMBs for Denied Claims.--
In general, use appropriate existing claim adjustment reason, line level remark, and MSN/EOMB codes and messages.

4174.5 Transmyocardial Revascularization (TMR) for Treatment of Severe Angina.--

A. Summary.--Transmyocardial Revascularization is covered as a late or last resort for patients with severe angina (stable or unstable) for claims with dates of service on or after July 1, 1999. The angina symptoms must be caused by areas of the heart not amenable to surgical therapies. (For more information regarding coverage, refer to §35-94 of the Medicare Coverage Issues Manual.)

B. Billing Instructions for Transmyocardial Revascularization--Providers should use Current Procedures Terminology code 33999 (unlisted procedure, cardiac surgery) to bill for their professional service for this procedures. Professional services must be billed on Form HCFA-1500 paper or electronic. Follow current guidelines for processing claims submitted with a miscellaneous code.