
Medicare

Carriers Manual

Part 3 - Claims Process

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NEW/REVISED MATERIAL--EFFECTIVE DATE: 10/01/00

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Section 4183, Stem Cell Transplantation, provides claims processing information for the coverage of stem cell transplantation. Though this information had not been previously included in the Medicare Carriers Manual, stem cell transplantation has previously been covered by Medicare for certain situations. For claims with dates of service on or after **10/01/00**, autologous stem cell transplantation will be covered for Medicare beneficiaries with multiple myeloma, less than age 78 who have Durie-Salmon stage II or III newly diagnosed or responsive multiple myeloma and adequate cardiac, renal, pulmonary and hepatic function. Multiple rounds of autologous stem cell transplantation (known as tandem transplantation) will, however, remain non-covered. The Coverage Issues Manual also includes nonprimary amyloidosis as a non-covered condition and primary (AL) amyloidosis as a non-covered condition for Medicare beneficiaries age 64 or older.

Section 4183.1, General, provides background on stem cell procedures.

Section 4183.2, HCPCS and Diagnosis Code, provides proper coding for stem cell procedures.

Section 4183.3, Non-Covered Conditions, provides a listing of diagnosis not to be covered.

Section 4183.4, Edits, provides instructions to implement systems edits.

Section 4183.5, Suggested MSN/EOMB and RA Messages, provides generated messages for claims denial.

Notify providers of the coverage changes and conditions of claims processing 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.

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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 in January 2000. Start your count beginning February 2000. The beneficiary is eligible to receive another screening PSA test in January 2001 (the month after 11 months have passed.)

4182.5 CWF Edits.--Effective for dates of service January 1, 2000, and later, CWF will edit prostate cancer screening tests and procedures for age, frequency, sex, and valid HCPCS code.

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 transplantation 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:

o 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

o 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. Multiple rounds of autologous stem cell transplantation (known as tandem transplantation) will, however, remain non-covered.

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.

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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 Tandem transplantation (multiple rounds of autologous stem cell transplantation) for patients with 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.