Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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This revision manualizes Program Memorandum AB-99-15, Change Request 839 dated April 1999 and Program Memorandum AB-99-22, Change Request 855 dated April 1999.

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents Chapter IV	4-3 - 4-4.5 (7 pp.)	4-3 - 4-4.5 (7 pp.)
4174.4 - 4174.5	4-45.1f19 - 445.1f20 (2 pp.)	4-45.1f19 (1p.)
4276 - 4276.4	4-68.4K (1p.)	----------

CLARIFICATION/MANUALIZATION--EFFECTIVE/IMPLEMENTATION DATE : Not Applicable

Section 4174.5, Transmyocardial Revascularization (TMR), manualizes instructions previously released in Program Memorandum AB-99-22, "Transmyocardial Revascularization (TMR) for Treatment of Severe Angina," dated April 1999. This new section provides coverage of TMR as a late or last resort for patients with severe (Canadian Cardiovascular Society Classification Classes III or IV) angina (stable or unstable) for claims with dates of service furnished on or after July 1, 1999.

Sections 4276 - 4276.4 Medicare Coverage of Abortion Services, manualizes instructions previously released in Program Memorandum AB-9-15, "Medicare Coverage of Abortion Services," dated April 1999. This new section provides for coverage of abortion services where the pregnancy is a result of an act of rape or incest, or the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

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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Section

Submission of Claims to Medigap Insurers

Global Surgery

National Emphysema Treatment Trial

CHAPTER IV

****__Note:__ Advise providers of this payment requirement and recommend that they coordinate the billing of their claims to avoid delays resulting from a claim for G0161 preceding the corresponding claim for G0160.*

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 G0160 or G0161 which indicates that the beneficiary was female.

b. Any G0160 claim for which there is already a record of a paid claim for G0160 for the same beneficiary for the same date of service.

c. Any G0161 claim for which no record exists for payment for a corresponding claim for G0160, i.e., a claim for a G0160 procedure performed for the same beneficiary for the same date of service.

d. Any G0161 claim for which a record exists for a previous paid claim for G0161 for the same beneficiary for the same date of service.

Deny the CWF rejections and send provider remittance advice messages and Medicare Summary Notices (MSNs)/Explanations of Medicare Benefits (EOMBs) as indicated in §4174.C

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. For claims for G0161 which CWF has rejected because there is no record of payment for the corresponding claim for G0160, use the following codes and messages:

1. Claim Adjustment (CAS) Reason Code and Message.--

107 Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.

2. Line Level Remark Code and Message.--

M121 We pay for this service only when performed with a covered cryosurgical ablation.

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.

4276. ABORTION SERVICES

4276.1 Conditions of Coverage.--Effective for services furnished on or after October 1, 1998, Medicare will cover abortions procedures in the following situations:

1. If the pregnancy is the result of an act or rape or incest; or

2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

4276.2 Billing Instructions.--The "G7" modifier must be used with the following CPT codes in order for these services to be covered when the pregnancy resulted from rape or incest, or the pregnancy is certified by a physician as life threatening to the mother:

59840	59851	59856
59841	59852	59857
59850	59855	59866

4276.3 Common Working File (CWF) Edits.--CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with the "G7" modifier and one of the above CPT codes.

4276.4 Medicare Summary Notice (MSN) Explanation of Your Medicare Benefits (EOMB)/Remittance Advice Message.--If a claim is submitted with one of the above CPT procedure codes but no "G7" modifier the claim should be denied. State on the MSN or the EOMB the following message:

"This service was denied because Medicare only covers this service under certain circumstances." (MSN Message 21.21, EOMB Message 21.32).

For the remittance advice use existing American National Standard Institute (ANSI) X12-835 claim adjustment reason code B5, "Claim/service denied/reduced because coverage guidelines were not met or were exceeded."