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 1632

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4173.6 - 4174.5	4-45.1f17 - 4-45.1f20 (4 pp.)	4-45.1f17 - 4-45.1fl19 (3 pp.)

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

Sections 4174.1, 4174.3, and 4174.4, regarding cryosurgery of the prostate gland, are revised to reflect the addition, effective July 1, 2001, of coverage for cryosurgery of the prostate gland performed as salvage therapy under certain limited conditions.

Section 4174.1, Summary, is revised to add the coverage conditions for this new benefit.

Section 4174.3, Payment and Coding Requirements, is revised to add the payment and coding requirements for this new benefit.

Section 4174.4, Processing Claims to Ensure That Payment Conditions Are Met, is revised to broaden the instruction to include the new coverage.

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.

Carriers provide necessary information regarding this topic in your next bullentin.

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.

A. For Claims With Dates Of Service On Or After July 1, 1999.--Medicare covers cryosurgery of the prostate gland as primary treatment for patients with clinically localized prostate cancer, stages T1-T3.

B. For Claims With Dates of Service On or After July 1, 2001.--In addition to covering cryosurgery of the prostate gland as primary treatment for patients having the conditions noted above, Medicare covers this procedure as salvage therapy for patients meeting the following requirements:

1. Having recurrent localized prostate cancer;
2. Having failed a trial of radiation therapy as their primary treatment; and
3. Meeting one of the following criteria:
   (a) Stage T2B or below; or
   (b) Gleason score less than 9; or
   (c) PSA less that 8 ng/mL.

NOTE: Medicare does **not** cover cryosurgery of the prostate gland performed as salvage therapy after failure of other therapies as the primary treatment.

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 1. **A primary treatment** for patients with clinically localized prostate cancer, stages T1-T3. 2. **Salvage therapy** ** for patients a) Having recurrent, localized prostate cancer **and** b) Failing a trial of radiatiaon therapy as their primary treatment **and** c) Meeting one of these conditions: Stage T2B or below; Gleason score less than 9; PSA less than 8 ng/mL	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.
**Effective for claims with dates of service on or after July 1, 2001.

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 coverage requirements, 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.