Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1947

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NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2002*
IMPLEMENTATION DATE: January 1, 2002

This transmittal manualizes CR 1717, Transmittal Number B-01-46, dated July 25, 2001.

Section 4184, Glaucoma Screening, is added to provide for payment for glaucoma screening for eligible beneficiaries.

Section 4184.1, Conditions of Coverage, provides a summary of the conditions under which glaucoma screening is covered.

Section 4184.2, Claims Submission Requirements and Applicable HCPCS Codes, provides the HCPCS codes and type of service code needed for submitting claims.

Section 4184.3, Calculating the Frequency, provides the methodology for calculating whether a claim is payable under coverage frequency guidelines.

Section 4184.4, Common Working File (CWF) Edits, describes the applicable CWF edits.

Section 4184.5, Claims Editing, describes claims editing and monitoring requirements.

Section 4184.6, Diagnosis Coding Requirements, provides the diagnosis code for glaucoma screening claims.

Section 4184.7, Payment Methodology, provides payment for glaucoma screening claims made on the basis of the Medicare physician fee schedule.

Section 4184.8, Remittance Advice Notices, provides remittance advice messages for use when denying claims.

Section 4184.9, Medicare Summary Notice (MSN) and Explanation of Medicare Benefits (EOMB) Messages, provides MSN and EOMB messages for use where appropriate.

These instructions should be implemented within your current operating budget.

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

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CHAPTER IV

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CHAPTER IV

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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 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.

4184. GLAUCOMA SCREENING

4184.1 Conditions of Coverage.--The regulations implementing the Benefits Improvements and Protection Act of 2000, §102, provide for annual coverage for glaucoma screening for beneficiaries in the following high risk categories: (1) Individuals with diabetes mellitus, (2) Individuals with a family history of glaucoma, or (3) African-Americans age 50 and over. Medicare will pay for glaucoma screening examinations where they are furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist, who is legally authorized to perform the services under State law.

Screening for glaucoma is defined to include: (1) A dilated eye examination with an intraocular pressure measurement; and (2) A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination. Payment may be made for a glaucoma screening examination that is performed on an eligible beneficiary after at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed. Coverage applies to glaucoma screening examination services performed on eligible beneficiaries on or after January 1, 2002.

4184.2 Claims Submissions Requirements and Applicable HCPCS Codes.--Claims for screening for glaucoma should be submitted on Form HCFA-1500 or electronic equivalent. Claims must be prepared and submitted by physicians and providers in accordance with the general instructions in the Medicare Carriers Manual (MCM), Part 4, §2010, Purpose of Health Insurance Claim Form HCFA-1500. Review and adjudicate claims in accordance with MCM, Part 3, §4020, Review of the Health Insurance Claim Form HCFA-1500.

Use the following HCPCS codes to bill for glaucoma screening:

G0117 - Glaucoma screening for high risk patients furnished by a physician; and

G0118 - Glaucoma screening for high risk patients furnished under the direct supervision of a physician.

The type of service for the above G codes is: TOS Q.

4184.3 Calculating the Frequency.--Once a beneficiary has received a covered glaucoma screening procedure, the beneficiary may receive another procedure after 11 full months have passed. To determine the 11-month period, start your count beginning with the month after the month in which the previous covered screening procedure was performed.

4184.4 Common Working File (CWF) Edits.--Beginning January 1, 2002, CWF edits will be implemented for dates of service January 1, 2002, and later. CWF will edit glaucoma screening for frequency and valid HCPCS code.

4184.5 Claims Editing.--Nationwide claims processing edits for pre or postpayment review of claim(s) for glaucoma screening are not required at this time. Monitor claims to assure that they are paid only for covered individuals and perform medical review as appropriate. You may develop local medical review policy and edits for such claims(s).

4184.6 Diagnosis Coding Requirements.--Bill glaucoma screening using screening (“V”) code V80.1 (Special Screening for Neurological, Eye, and Ear Diseases, Glaucoma). Claims submitted without a screening diagnosis code may be returned to the provider as unprocessable (refer to MCM, Part 3, §3005 for more information about incomplete or invalid claims).

4184.7 Payment Methodology.--Pay for glaucoma screening on the basis of the Medicare physician fee schedule. Deductible and coinsurance apply. Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge (refer to MCM, Part 3, §7555 for more information about the Medicare limiting charge).

4184.8 Remittance Advice Notices.--Use appropriate remittance advice(s) when denying payment for glaucoma screening. Use the following messages where applicable:

- If the services were furnished before January 1, 2002, use existing remittance advice claim adjustment reason code 26 “Expenses incurred prior to coverage” at the line level.

- If the claim for glaucoma screening is being denied because the minimum time period has not elapsed since the performance of the same Medicare-covered procedure, use existing remittance advice claim adjustment reason code 119 “Benefit maximum for this time period has been reached” at the line level.

- If the service is being denied because the individual is not an African-American age 50 or over, use existing remittance advice claim adjustment reason code 6, "The procedure code is inconsistent with the patient's age," and existing remark codes M83, "Service not covered unless the patient is classified as at high risk," and M82, "Service not covered when patient is under age 50." Report these codes at the line level.

- If the service is being denied because the patient does not have diabetes or there is no family history of diabetes, use existing remittance advice claim adjustment reason code B5, "Payment adjusted because coverage/program guidelines were not met or were exceeded." The zero payment for the service will indicate the denial. In addition, report remark code M83, "Service is not covered unless the patient is classified as at high risk" at the line level.

4184.9 Medicare Summary Notice (MSN) and Explanation of Medicare Benefits (EOMB) Messages.--Use the following MSN and EOMB messages where appropriate:

- If a claim for a screening for glaucoma is being denied because the service was performed prior to January 1, 2002, use the new (May 2001) MSN or EOMB message:

  - "This service is not covered prior to January 1, 2002." (MSN Message 16.54, EOMB Message 20.3)

- The Spanish version of the MSN or EOMB messages should read:

  - "Este servicio no está cubierto antes del 1 de enero de 2002."

- If a claim for screening for glaucoma is being denied because the minimum time period has not elapsed since the performance of the same Medicare-covered procedure, use 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:

- The Spanish version of the MSN or EOMB messages should read:

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

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.