CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services(CMS)**
Transmittal 1111	**Date: NOVEMBER 9, 2006**
	Change Request 5376

SUBJECT: Clarification on Billing for Cryosurgery of the Prostate Gland

I. SUMMARY OF CHANGES: This Change Request moves the instructions on cryosurgery of the prostate from Chapter 18, Screening and Preventive Services, to Chapter 32, Billing Requirements for Special Services. In addition the acceptable revenue codes are expanded to include 0360, 0361, and 0369 revenue codes, and the payment for Indian Health Service facilities is corrected.

Please note that a revision to §250 and §250.2 of Chapter 4, Part B Hospital (Including Inpatient Hospital Part B and OPPS) is included with this CR. We have clarified the need for Critical Access Hospitals (CAHs) to make an annual election if they wish to receive payment under Method II. There are no policy changes attached to the sections on CAHs.

New / Revised Material
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	TOC Chapter 32
R	4/250/Special Rules for Critiacal Access Hospital Outpatient Billing
R	4/250.2/Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 Percent Fee Schedule for Professional Services
D	18/51/Cryosurgery of the Prostate Gland
D	18/51/51.1/Coverage
D	18/51/51.2/Billing

D	18/51/51.3/Payment
N	32/180/Cryosurgery of the Prostate Gland
N	32/180/180.1/Coverage Requirements
N	32/180/180.2/Billing Requirements
N	32/180/180.3/Payment Requirements

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1111	Date: November 9, 2006	Change Request:5376

SUBJECT: Clarification on Cryosurgery of the Prostate Gland

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

I. GENERAL INFORMATION

A. Background: Program Memorandum A-99-15, dated April 1999 implemented cryosurgery of the prostate gland. This instruction was subsequently modified twice, once to manualize it (Change Request (CR)1632 dated June 11, 2001) and later to correct the revenue code (CR 3168 dated July 30, 2004). This CR expands the revenue codes in which cryosurgery of the prostate may be billed. Providers may use ANY of the detail codes in revenue code 036x to bill this service.

B. Policy: Cryosurgery of the prostate, also known as cryoablation of the prostate (CAP), destroys prostate gland tissue by applying extremely cold temperatures; this reduces the size of the prostate gland.

NOTE : A revision to §§250 and 250.2 of Chapter 4 is included with this CR. These revisions clarify that CAHs that wish to be paid using the optional method (Method II) for professional outpatient services must make the election to do so annually. There are no policy changes related to this clarification.

II. BUSINESS REQUIREMENTS

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5376.1	FISS shall expand the revenue codes in which claims for cryosurgery of the prostate gland may be performed to include 0360 and 0369, as well as revenue code 0361.							X				
5376.2	Any contractors currently limiting the acceptable revenue codes for cryosurgery of the prostate gland shall turn off any such edits.	X		X								

III. PROVIDER EDUCATION

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5376.3	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X								

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Cindy Murphy, cindy.murphy@cms.hhs.gov or Susan Guerin, susan.guerin@cms.hhs.gov

Post-Implementation Contact(s): Local Regional Office

VI. FUNDING

A. ***For TITLE XVIII Contractors:***
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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250 – Special Rules for Critical Access Hospital Outpatient Billing

(Rev.1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

For cost reporting periods beginning before October 1, 2000, a CAH will be paid for outpatient services under the method in §250.1. The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. This provision was implemented with respect to cost reporting periods starting on or after October 1, 2001.

For cost reporting period beginning on or after October 1, 2001, the CAH will be paid under the method in item 1 below unless it elects to be paid under the method in §250.1.

If a CAH elects payment under the elective method (cost-based facility payment plus fee schedule for professional services) for a cost reporting period, that election is effective for the entire cost reporting period to which it applies. If the CAH wishes to make a new election or change a previous election, that election should be made in writing, *made on an annual basis and delivered* to the appropriate FI, at least 30 days in advance of the beginning of the affected cost reporting period.

All outpatient CAH services, other than pneumococcal pneumonia vaccines, influenza vaccines, administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests are subject to Part B deductible and coinsurance. Regardless of the payment method applicable for a period, payment for outpatient CAH services is not subject to the following payment principles:

- Lesser of cost or charges,
- Reasonable compensation equivalent (RCE) limits,
- Any type of reduction to operating or capital costs under 42 CFR 413.124 or 413.30(j)(7), or
- Blended payment rates for ASC-type, radiology, and other diagnostic services.

See §250.4 below regarding payment for screening mammography services

250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services

(Rev.1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method by filing a written election with the intermediary *on an annual basis* at least 30 days before start of the Cost Reporting period to which the election applies. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period for the CAH.

However, the Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changes the requirement that each practitioner rendering a service at a CAH that has elected the optional method, reassign their billing rights to that CAH. This provision allows each practitioner to choose whether to reassign billing rights to the CAH or file claims for professional services through their carrier. The reassignment will remain in affect for that entire cost reporting period.

The individual practitioner must certify, using the Form CMS 855R, if he/she wishes to reassign their billing rights. The CAH must then forward a copy of the 855R to the intermediary *and the appropriate carrier*, must have the practitioner sign an attestation that clearly states that the practitioner will not bill the carrier for any services rendered at the CAH once the reassignment has been given to the CAH. This "attestation" will remain at the CAH.

For CAHs that elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. For CAHs electing the optional method on or after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004. Under this election, a CAH will receive payment from their intermediary for professional services furnished in that CAH's outpatient department. Professional services are those furnished by all licensed professionals who otherwise would be entitled to bill the carrier under Part B.

Payment to the CAH for each outpatient visit (reassigned billing) will be the sum of the following:

- For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. On the ANSI X12N 837 I, list the facility service(s) rendered to outpatients using the appropriate revenue code. The FI will pay the amount equal to the lesser of 80 percent of 101 percent of the reasonable costs of its outpatient services, or the 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts, plus:
- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

- The FI uses the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for all the physician/professional services rendered in a CAH that elected the all-inclusive method. The data in the supplemental file are in the same format as the abstract file. The FI will pay 115 percent of whatever Medicare would pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) Payment for non physician practitioners will be 115 percent of 85 percent of the allowable amount under the physician fee schedule; and

  For a non-participating physician service, a CAH must place modifier AK on the claim. The intermediary should pay 95 percent of the payment amount for non-participating physician services. Calculating 95 percent of 115 percent of an amount is equivalent to multiplying the amount by a factor of 1.0925. To calculate the Medicare limiting charge for a physician service for a locality, multiply the fee schedule amount by a factor of 1.0925.

  Payment for non-physician practitioners will be 115 percent of the allowable amount under the physician fee schedule.

  If a non-physician practitioner renders a service, one of the following modifiers must be on the applicable line:

  GF - Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for CRNA services, the claim is returned to the provider.)

  SB - Services rendered in a CAH by a nurse midwife.

  AH - Services rendered in a CAH by a clinical psychologist.

  AE - Services rendered in a CAH by a nutrition professional/registered dietitian.

- Outpatient services, including ASC type services, rendered in an all-inclusive rate provider should be billed using the 85X type of bill (TOB). Non-patient laboratory specimens are billed on TOB 14X.

  The (MPFS) supplemental file is used for payment of all physician/professional services rendered in a CAH that has elected the optional method. If a HCPCS has a facility rate and a non-facility rate, pay the facility rate.

CORF SERVICES SUPPLEMENTAL FEE SCHEDULE
CRITICAL ACCESS HOSPTIAL FEE SCHEDULE

DATA SET NAMES: MU00.@BF12390.MPFS.CY05.SUPL.V1122.FI

This is the final physician fee schedule supplemental file.

RECORD LENGTH: 60

RECORD FORMAT: FB

BLOCK SIZE: 6000

CHARACTER CODE: EBCDIC

SORT SEQUENCE: Carrier, Locality HCPCS Code, Modifier

Data Element Name	Location	Picture	Value
1 - HCPCS	1-5	X(05)	
2 - Modifier	6-7	X(02)	
3 - Filler	8-9	X(02)	
4 - Non-Facility Fee	10-16	9(05)V99	
5 - Filler	17-17	X(01)	
6 - PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.
7 - Filler	19	X(1)	
8 - Facility Fee	20-26	9(05)V99	
9 - Filler	27-30	X(4)	
10 - Carrier Number	31-35	X(05)	
11 - Locality	36-37	X(02)	
12 - Filler	38-40	X(03)	
13 - Fee Indicator	41-41	X(1)	Field not populated— filled with spaces.
14 - Outpatient Hospital	42-42	X(1)	Field not populated—Filled with spaces.
15 - Status Code	43-43	X(1)	Separate instructions will be issued for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it's separately payable if the service is covered.
14 - Filler	44-60	X(17)	

If a non-physician (e.g., Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) renders a service, the "GF" modifier must be on the applicable line. **The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for CRNA services, the claim is returned to the provider.**

Health Professional Shortage Area (HPSA) Incentive Payments for Physicians

Section 1833 (m) of the Social Security Act, provides incentive payments for physicians who furnish services in areas designated as HPSAs under section 332(a)(1)(A) of the Public Health Service (PHS) Act. This statute recognizes geographic-based, primary medical care and mental health HPSAs, are areas for receiving a 10 percent bonus payment. The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating shortage areas.

Physicians, including psychiatrists, who provide covered professional services in a primary medical care HPSA, are entitled to an incentive payment. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. The bonus is payable for psychiatric services furnished in either a primary care HPSA, or a mental health HPSA. Dental HPSAs remain ineligible for the bonus payment.

Physicians providing services in either rural or urban HPSAs are eligible for a 10-percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although, frequently, this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

If the CAH electing the Optional Method (Method II) is located within a primary medical care HPSA, and/or mental health HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. Therefore, payments to such a CAH for professional services of physicians in the outpatient department will be 115 percent **times** the amount payable under fee schedule **times** 110 percent. An approved Optional Method CAH that is located in a HPSA County should notify you of its HPSA designation **in writing**. Once you receive the information, place an indicator on the provider file showing the effective date of the CAH's HPSA status. The CMS will furnish quarterly lists of mental health HPSAs to intermediaries.

The HPSA incentive payment is 10 percent of the amount actually paid, not the approved amount. Do not include the incentive payment in each claim. Create a utility file so that you can run your paid claims file for a quarterly log. From this log you will send a quarterly report to the CAHs for each physician payment, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment sent along with the report to the CAH. If any of the claims included on report are adjusted, be sure the adjustment also goes to the report. If an adjustment request is received after the end of the quarter, any related adjustment by the FI will be included on next quarter's report. CAHs must be sure to keep adequate records to permit distribution of the HPSA bonus payment when received. If an area is designated as both a mental health HPSA and a primary medical care HPSA, only one 10 percent bonus payment shall be made for a single service.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

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(Rev.1111, 11-09-06)

180 – Cryosurgery of the Prostate Gland

(Rev.1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

Cryosurgery of the prostate gland, also known as cryosurgical ablation of the prostate (CAP), destroys prostate tissue by applying extremely cold temperatures in order to reduce the size of the prostate gland.

180.1 - Coverage Requirements

(Rev.1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

Medicare covers cryosurgery of the prostate gland effective for claims with dates of service on or after July 1, 1999. The coverage is for:

1. *Primary treatment of patients with clinically localized prostate cancer, Stages T1 – T3 (diagnosis code is 185 – malignant neoplasm of prostate).*

2. *Salvage therapy (effective for claims with dates of service on or after July 1, 2001 for patients:*
   a. *Having recurrent, localized prostate cancer;*
   b. *Failing a trial of radiation therapy as their primary treatment; and*
   c. *Meeting one of these conditions: State T2B or below; Gleason score less than 9 or; PSA less than 8 ng/ml.*

180.2 - Billing Requirements

(Rev.1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

Claims for cryosurgery for the prostate gland are to be submitted on the ANSI X12 ASC 837, or, in exceptional circumstances, on a hard copy Form CMS – 1450. This procedure can be rendered in an inpatient or outpatient hospital setting (types of bill (TOBs) 11x 13x, 83x, and 85x).

The FI will look for the following when processing claims with cryosurgery services:

- *Diagnosis Code 185 (must be on all cryosurgical claims);*
- *For outpatient claims HCPCS 55873 and revenue codes 0360, 0361, or 0369 Cryosurgery ablation of localized prostate cancer, stages T1- T3 (includes ultrasonic guidance for interstitial cryosurgery probe placement, postoperative irrigations and aspiration of sloughing tissue included) must be on all outpatient claims; and*

- *For inpatient claims procedure code 60.62 (perineal prostatectomy- the definition includes cryoablation of prostate, cryostatectomy of prostate, and radical cryosurgical ablation of prostate) must be on the claim.*

180.3 – Payment Requirements

(Rev.1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

This service may be paid as a primary treatment for patients with clinically localized prostate cancer, Stages T1 – T3. The ultrasonic guidance associated with this procedure will not be paid for separately, but is bundled into the payment for the surgical procedure. 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.

Effective July 1, 2001, cryosurgery performed as salvage therapy, will be paid only according to the coverage requirements described above.

Type of facility and setting determines the basis of payment:

- *For services performed on an inpatient or outpatient basis in a CAH, TOBs 11x and 85x: the FI will pay 101 percent of reasonable cost minus any applicable deductible and coinsurance.*
- *For services performed on an inpatient basis in short term acute care hospitals, (including those in Guam, America Samoa, Virgin Islands, Saipan, and Indian Health Services Hospitals) TOB 11x: the FI will pay the DRG payment minus any applicable deductible and coinsurance.*
- *For services performed on an outpatient basis in hospitals subject to the Outpatient PPS, TOB 13x: the FI will pay the assigned APC minus any applicable deductible and coinsurance.*
- *For outpatient services in hospitals that are exempt from OPPS (such as in American Samoa, Virgin Islands, Guam, and Saipan) TOBs 13x: the FI will pay reasonable cost, minus any applicable deductible and coinsurance.*
- *For outpatient services in Indian Health Service hospitals TOBs 13x and 83x: the FI will pay the ASC payment amount for TOB 83x. minus any applicable deductible and coinsurance.*
- *For inpatient or outpatient services in hospitals in Maryland, make payment according to the State Cost Containment system.*

For services performed on an inpatient basis: the hospitals exempt from inpatient acute care PPS shall be paid on reasonable cost basis, minus any applicable deductible and coinsurance.