CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

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CHANGE REQUEST 3684

SUBJECT: Manualization of Carrier Claims Processing Instructions for Stem Cell Transplantation

I. SUMMARY OF CHANGES: This CR manualizes the billing and coding requirements for stem cell transplantation for the IOM. This information was in the Medicare Carrier Manual (MCM) but was never transferred into the IOM. **NO NEW INFORMATION IS BEING ADDED AND NO SYSTEM CHANGES ARE REQUIRED.**

NEW/REVISED MATERIAL - EFFECTIVE DATE*: Not Applicable
IMPLEMENTATION DATE: Not Applicable

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	32/90/Table of Contents
N	32/90 - Stem Cell Transplantation
N	32/90.1 - General
N	32/90.2 - HCPCS and Diagnosis Coding
N	32/90.3 - Non-Covered Conditions
N	32/90.4 - Edits
N	32/90.5 - Suggested MSN and RA Messages

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

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(Rev.486, 03-04-05)

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90 STEM CELL TRANSPLANTATION

(Rev. 486, Issued: 03-04-05, Effective Date/Implementation Date: N/A)

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 Publication 100-02, National Coverage Determinations Manual, Section 110 for a complete description of covered and noncovered conditions. The following sections contain claims processing instructions for carrier claims. For institutional claims processing instructions, please refer to Publication 100-04, Chapter 3, Section 90.3

90.1 General

(Rev. 486, Issued: 03-04-05, Effective Date/Implementation Date: N/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.

- *Autologous Stem Cell Transplantation*

Autologous stem cell transplantations 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.

90.2 HCPCS and Diagnosis Coding

(Rev. 486, Issued: 03-04-05, Effective Date/Implementation Date: N/A)

• Allogeneic Stem Cell Transplantation

- Effective for services performed on or after August 1, 1978:

-- For the treatment of leukemia or leukemia in remission, providers shall use ICD-9-CM codes 204.00 through 208.91 and HCPCS code 38240.

-- For the treatment of aplastic anemia, providers shall use ICD-9- CM codes 284.0 through 284.9 and HCPCS code.

- Effective for services performed on or after June 3, 1985:

-- For the treatment of severe combined immunodeficiency disease, providers shall use ICD-9-CM code 279.2 should be and HCPCS code 38240.

-- For the treatment of Wiskott-Aldrich syndrome, providers shall use ICD-9-CM code 279.12 and HCPCS code.

- Effective for services performed on or after May 24, 1996:

-- 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.

• Autologous Stem Cell Transplantation.--Is covered under the following circumstances effective for services performed on or after April 28, 1989:

- 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, providers shall use 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 and HCPCS code 38241.

- For the treatment of resistant non-Hodgkin's lymphomas for those patients presenting with poor prognostic features following an initial response, providers shall use 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 and HCPCS code.

- For the treatment of recurrent or refractory neuroblastoma, providers shall use ICD-9-CM codes Neoplasm by site, malignant, the appropriate HCPCS code and HCPCS code 38241.

- For the treatment of advanced Hodgkin's disease for patients who have failed conventional therapy and have no HLA-matched donor, providers shall use ICD-9-CM codes 201.00 - 201.98 and HCPCS code.

• Autologous Stem Cell Transplantation.--Is covered under the following circumstances effective for services furnished on or after October 1, 2000:

- 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), providers shall use ICD- 9-CM code 203.00 or 238.6 and HCPCS code 38241.

- For the treatment of recurrent or refractory neuroblastoma, providers shall use appropriate code (see ICD-9-CM neoplasm by site, malignant) and HCPCS code 38241.

- 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.

90.3 Non-Covered Conditions

(Rev. 486, Issued: 03-04-05, Effective Date/Implementation Date: N/A)

Autologous stem cell transplantation is not covered for the following conditions:

• Acute leukemia not in remission (ICD-9-CM codes 204.00, 205.00, 206.00, 207.00 and 208.00);

• Chronic granulocytic leukemia (ICD-9-CM codes 205.10 and 205.11);

• Solid tumors (other than neuroblastoma) (ICD-9-CM codes 140.0 through 199.1); or

• 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).

• 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).

• 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 80.2 or specifically designated as non-covered in this section will be at the discretion of the individual carrier.

90.4 Edits

(Rev. 486, Issued: 03-04-05, Effective Date/Implementation Date: N/A)

Appropriate diagnosis to procedure code edits should be implemented for the covered conditions and services in 90.2

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.

90.5 Suggested MSN and RA Messages

(Rev. 486, Issued: 03-04-05, Effective Date/Implementation Date: N/A)

The contractor shall use an appropriate MSN and RA message such as the following:

MSN - 15.4, The information provided does not support the need for this service or item;

RA - 150, Payment adjusted because the payer deems the information submitted does not support this level of service.