CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 895

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MARCH 24, 2006

Change Request 4365

SUBJECT: Expansion of Glaucoma Screening Services

I. SUMMARY OF CHANGES: Medicare coverage for glaucoma screening for certain beneficiaries considered to be at high-risk is being expanded to cover Hispanic Americans age 65 or over. This instruction provides appropriate remittance advice notices for use when payments are denied when age requirements of coverage are not met.

NEW/REVISED MATERIAL
EFFECTIVE DATE: January 1, 2006
IMPLEMENTATION DATE: April 3, 2006

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:
R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUB SECTION/TITLE
R	18/70.4/Remittance Advice Notices
R	18/70.5/MSN Messages

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 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: 895	Date: March 24, 2006	Change Request 4365

SUBJECT: Expansion of Glaucoma Screening Services

I. GENERAL INFORMATION

A. Background: On January 1, 2002, CMS implemented regulations at 42 CFR 410.23(a)(2), Conditions for and limitations on coverage of screening for glaucoma, requiring that the term "eligible beneficiary" be defined to include individuals 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.

B. Policy: The Physician Fee Schedule for Calendar Year 2006 Final Rule, 70 FR 70270, dated November 21, 2005, expands Medicare coverage of high-risk individuals eligible to receive glaucoma screening services to include Hispanic Americans age 65 and over. This expansion of coverage is effective for services performed on or after January 1, 2006, and revises 42 CFR 410.23(a)(2) accordingly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4365.1	Effective for dates of services on or after January 1, 2006, contractors shall pay claims for glaucoma screening services when performed on Hispanic-Americans age 65 and over.	X		X						
4365.2	Contractors shall apply current payment methodologies, rates, and payment policies for glaucoma screening services when these services are performed on Hispanic-Americans age 65 and over.	X		X						
4365.3	Contractors shall not search for and adjust claims with dates of service January 1, 2006, and forward, but shall adjust any claims brought to their attention.	X		X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
4365.4	Contractors shall deny claims if coverage criteria at Pub. 100-02, chapter 15, section 280.1, are not met.	X		X						
4365.4.1	Contractors shall deny claims by returning remittance advice claim adjustment reason code 96 (Non-covered charge) and existing remark codes M83 (Service not covered unless the patient is classified as at high-risk) and N129 (This amount represents the dollar amount not eligible due to patient's age).	X		X						
4365.4.2	Contractors shall deny claims not meeting the age-related and/or ethnic-related coverage criteria at Pub. 100-02, chapter 15, section 280.1, by returning Medicare Summary Notice 21.21 (This service was denied because Medicare only covers this service under certain circumstances).	X		X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
4365.5	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "Medlearn 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	X		X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	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 Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Bill Larson (coverage), William.Larson@cms.hhs.gov, 410-786-4639, Tom Dorsey (Part B claims processing), Thomas.Dorsey@cms.hhs.gov, 410-786-7434, Bill Ruiz (Part A claims processing), William.ruiz@cms.hhs.gov, 410-786-9283 **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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70.4 - Remittance Advice Notices

(Rev. 895, Issued: 03-24-06; Effective: 01-01-06; Implementation: 04-03-06)

Appropriate remittance advice(s) must be used *by fiscal intermediaries and carriers* when denying payment for glaucoma screening. The following messages are used where applicable:

- If the services were furnished before January 1, 2002, use existing ANSI X12N 835 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 ANSI X12N 835 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 individual is not a Hispanic-American age 65 or over, use existing remittance advice claim adjustment reason code 96, “Non-covered charge,” and existing remark codes M83, “Service not covered unless the patient is classified as at high risk,” and N129, "This amount represents the dollar amount not eligible due to patient's age."*
- If the service is being denied because the patient does not have diabetes *mellitus,* or there is no family history of *glaucoma*, carriers 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.

70.5 - MSN Messages

(Rev. 895, Issued: 03-24-06; Effective: 01-01-06; Implementation: 04-03-06)

The following MSN messages where appropriate must be used.

If a claim for a screening for glaucoma is being denied because the service was performed prior to January 1, 2002, use the MSN message:

MSN Message 16.54:

> This service is not covered prior to January 1, 2002.

The Spanish version of the MSN message 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 message:

MSN Message 18.14:

> Service is being denied because it has not been [12/24/48] months since your last [test/procedure] of this kind.

The Spanish version of this MSN message should read:

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

If a claim for a screening for glaucoma is being denied because the age-related and/or ethnic-related coverage criteria are not met, use:

MSN Message 21.21:

> *This service was denied because Medicare only covers this service under certain circumstances.*

The Spanish version of this MSN message should read:

> *Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.*