

Coding and Billing Guidelines

Contractor Name

Wisconsin Physicians Service (WPS)

Contractor Number

00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302,
05402, 52280

Article Type

LCD Companion Article

Article Title

Billing and Coding Guidelines for INJ-039, Luteinizing Hormone-Releasing Hormone (LHRH) Analogs

Effective Date

03/18/2010

Revision Effective Date

04/19/2010

Ending Date

CMS National Coverage

Title XVIII of the Social Security Act section 1862(a) (1) (A). This section allows coverage and payment for those services that are considered medically reasonable and necessary.

Title XVIII of the Social Security Act section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Title XVIII of the Social Security Act section 1862(a) (1) (D).

CMS Pub. 100-2, Ch.15 §50

CMS Pub. 100-4, Ch. 17

CMS Pub. 100-8, Ch. 13, §5.4

Article Text

The information in this Coding and Billing Article is provided as a supplemental guideline that should be used with Local Coverage Determination (LCD) Luteinizing Hormone-Releasing Hormone (LHRH) Analogs. (LCD database ID number L30479). This LCD can be accessed on our contractor Web site at www.wpsic.com.

Medicare Contractors implement LCDs to apply the standard of reasonable and necessary in situations not covered by specific national policy.

A prior version of Billing and Coding Guidelines for Luteinizing Hormone-Releasing Hormone (LHRH) Analogs entitled Billing and Coding Guidelines for Gonadotropin-Releasing Hormone Analogs was previously in effect for WPS Medicare Part B.

Reasons for Denial

1. All other indications not listed in the "indications and Limitations of Coverage and/or Medical Necessity" section of the related policy.
2. The medical record does not verify that the service described by the HCPCS code was provided.
3. J9218 (leuprolide acetate [Lupron®], per 1 mg) is non-covered since this formulation is usually self administered.
4. J1675 (histrelin) acetate [Supprelin ®], 10 mg) is non-covered since this formulation is usually self-administered and/or is being used in lieu of a medication that normally is self-administrated.

Coding and Billing Guidelines

1. For the 10.8 mg dose of goserelin, bill J9202, three units. For the 11.25 dose of leuprolide, bill J1950, three units.
2. For the 22.5, 30 or 45 mg doses of leuprolide, bill J9217 three, four or six units respectively.
3. CPT codes 11981-11983 and 96402 may be used for clinical reasons other than administration of GnRH and are not assigned to any diagnosis included in INJ-039.
4. The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedent over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.
5. An advance beneficiary notification (ABN) may be used for outpatient services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

For claims submitted to the carrier or Part B MAC:

All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim

Claims for Luteinizing Hormone-Releasing Hormone (LHRH) Analogs services are payable under Medicare Part B in the following places of service:

Office (11), home (12), assisted living facility (13), group home (14), custodial care facility (33), and independent clinic (49). When administered in hospital inpatient (21), hospital outpatient (22) or skilled nursing facility (31), these drugs are covered and paid for under the Part A benefit and not billable to Part B.

When the leuprolide or histrelin implants are administered to a patient in a facility (POS = 21, 22, 24, 31, 51), the physician should bill only the surgical implant codes and not the drug. Administration, by injection, of an LHRH agonist to a patient in a facility (POS= 21, 22, 24, 31, 51) is considered not to be a physician service (it can be administered by the facility staff) and CPT code 96402 should **not** be billed. The drug also may **not** be billed.

Hospital Inpatient Claims:

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*

- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*
- *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

Other Comments:

Unless otherwise specified, italicized text represents quotation from one or more of CMS sources:

Published:

02/01/2010

Revision History/Explanation:

04/19/2010: Based on the following directive from CMS this article for LCD L30479 is revised effective 04/19/2010.

contractors shall not implement the LCA policy for any Part B drugs in new Local Coverage Determinations (LCDs). Contractors shall suspend and remove all LCA provisions in current LCDs and adjudicate claims without using LCA for all Part B drugs. Contractors shall no longer apply Chapter 15, Section 110.1.C.3 of the Benefit Policy Manual and Chapter 13, Sections 13.4(A) and the last sentence of 13.7.1 of the Program Integrity Manual in establishing LCDs for Part B drugs. (one)